

the

Canadian Nurse



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NUMBER 12

DECEMBER 1963

**Greetings for
Christmas
and
the New Year**

OWNED AND PUBLISHED BY

THE CANADIAN NURSES' ASSOCIATION

... and a Merry Christmas to you



THE CLINIC SHOE

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Between Ourselves

Christmas, the most important festival in the annals of Christian faiths, Christmas 1963 will soon be with us. The time when the festival was first observed is not known with any certainty. Clement of Alexandria wrote of it at the beginning of the third century as being a celebration of great antiquity. December 25 was fixed as the day by Chrysostom in the latter part of the fourth century. The widespread practice of presenting gifts at Christmas is presumed to have some connection with the story of the gifts presented to the Infant Jesus by the three Wise Men.

Christmas is primarily the time for festivities in the home. Parents will deny themselves even the simple necessities of life to provide lavishly for their children. Transportation facilities become so jammed with travellers that reservations for seats on trains or planes must be made two or three months in advance. For those of you who are "going home for Christmas" we hope the reservations have been secured. To all of you, we at the *Journal* pass along our wishes that this may be a truly happy Christmas.

* * *

This year, 1963, has established new records, circulation-wise, for your *Journal*. A complete count of the number of copies distributed is made each year in June and December. Last June, the count showed that 62,729 copies of the English edition and 11,272 copies of the French edition went into the mails for a grand total of 74,001 copies. We estimate that this month's count will probably show an increase of at least two thousand over the June figures!

When we noted the circulation "explosion" in writing to the editor of *International Nursing Review*, Miss Marjorie Wenger in her reply suggested that we should encourage our readers to "widen their horizons in nursing" by subscribing to the I.C.N. publication. Published six times a year, the annual subscription price to *International Nursing Review* is \$4.50. Subscriptions should be sent to ICN House, 1 Dean Trench Street, London SW1, England. So why not give yourself a worthwhile Christmas present?

* * *

The description of and comments regard-

ing the work on the active treatment geriatric ward, developed at Toronto Western Hospital, make exceedingly interesting reading. With the steadily increasing percentage of older people in our population, many more such special service areas should be set up in large hospitals across Canada. If the Toronto Western pattern is followed, the prospects of improved care for those of advanced years will be much brighter.

* * *

Our special Christmas treat for you is nonagenarian ANNIE BROOKE HIBBARD's "Nurse's Diary," her account of some of the hilarious episodes in her training days at the Montreal General Hospital at the turn of the century. Imagine paying only 25 cents for a three-course dinner!

* * *

For those who are charged with the responsibility of preparing budgets, the detailed instructions contained in Miss EDITH YOUNG's article should be of immeasurable assistance. Even making out and sticking to a personal budget is a task that most of us regard as unconscionable, unnecessary and unproductive. We don't save any money anyway! Our sympathies go out to nurses who have to spend weary hours budgetting expenses for a school of nursing as for the whole nursing service program in a hospital.

* * *

When a friend of our, who had worn various types of hearing aids for many years, walked into the office without any visible apparatus, and particularly when she turned her back on us to negate any possible lip reading, we were immensely interested to learn what new treatment had restored her hearing. Her surgeon has explained the technique used in his "Surgery for Otosclerosis." On selected patients it really performs a minor miracle. This article is reprinted with permission from *Modern Medicine of Canada*.

Every reform, however necessary, will by weak minds be carried to an excess, that itself will need reforming.

— SAMUEL TAYLOR COLERIDGE



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*The views expressed in the various articles are the views of the authors and
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- ☐ 1. Rosenberg, S., Oster, K. A., Kallos, A. and Burroughs, W.: A.M.A. Arch. Dermat. 76:330, September, 1957.
- ☐ 2. Derzavis, J. L. and Mulinos, M. G.: Med. Ann. D. C. XXX:133, March, 1961.
- ☐ 3. Schwinner, M. and Mulinos, M. G.: Antibiot., Med. & Clin. Therapy 4:403, July, 1957.
- ☐ 4. Rosenberg, S. and Oster, K. S.: Conn. State Med. J. 19:171, March, 1955.
- ☐ 5. Tyson, T. L.: J. Invest. Dermat. 14:323, May, 1950.

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The Journal presents pharmaceuticals for information. Nurses understand that only a physician may prescribe.



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NURSE...



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or acid
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for the tummy

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For professional sample of soothing Resinol, write to: Resinol Chemical Co., TCN-49, Baltimore 1, Md.

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AND SOAP

Random Comments

Dear Editor:

My husband is in Nigeria, training primary school teachers under Canada's "Special Aid for African Countries." Aware of the dire need for reading materials in schools here, the wife of another Canadian teacher and I, wrote to Canadians last year asking them to send discarded children's books to us for distribution. The generosity of Canadians has resulted in 29 schools, to date, being the recipients of many library books.

Recently, the director of nurses training for the City Hospital, Kano, approached my husband to enquire whether or not we had any professional nursing texts. The enrollment in the school of nursing has increased from 30 to 90 students and the director states that he has only 20 reference books.

At the time, we had only a few secondary school health books. We had, however, such a generous response from Canadians before, that we promised the director that we would ask for books for his library.

Would you publish an appeal in the *Journal* asking subscribers to please mail any useful books on nursing, child care, and related subjects to the following address:

"BOOKS FROM CANADA"
P.M.B. 3077,
KANO, N. NIGERIA.

Incidentally, although the director of nursing is English, he knew of *The Canadian Nurse* as a particularly fine nursing journal. He would be grateful to receive back copies of any issue which your subscribers would be willing to send.

Bound books can be mailed in a maximum weight parcel of 11 pounds for 89 cents.

Each book received will be placed where it will help to train nurses for this country.

(Mrs.) ROSE HUTCHENS,
Kano, N. Nigeria.

Dear Editor:

I am greatly concerned about the distribution of a paper back book by Joan Lawson, R.N. which represents itself to be a

true account of various cases involving relationships, mainly sexual, between nurses, patients and/or doctors. This book, read by an uninformed public will be taken as the truth. I feel, therefore, that it is a slight upon the nursing profession as a whole.

I would like to know your policy or attitude regarding a book of this sort written by a nurse who has taken the Nightingale Pledge and yet has violated two main points: 1. I will do all in my power to elevate the standard of my profession; 2. I will hold in confidence all personal matters committed to my keeping, and all family affairs coming to my knowledge in the practice of my profession.

I feel strongly, in the interest of the high standards expected of our profession that this "nurse" should be severely reprimanded. Efforts should be taken by the CNA to appeal to publishers of other fictional books and magazines which deal with nurses and their relationships with doctors and patients so that a halt may be put to the distribution of such works.

(Mrs.) WENDY J. CHAMBERS, R.N.
Victoria, B.C.

¶ Each time any nurse buys a paperback that appears to explore free love, adultery, homosexuality or drunkenness, she contributes to the breakdown of society. Ed.

Dear Editor:

I enjoy reading the *Journal* and find it superior to other nursing journals. Perhaps if our discontented Canadian nurses subscribed to another nursing journal for a year we would hear less criticism and more praise about *The Canadian Nurse*.

(Mrs.) LEONA VICKERS, California.

* * *

FILM LISTINGS

Rehabilitation Techniques in Hemiplegia

A 30-minute colored film photographed at Sunnybrook Hospital, Toronto. The progress of an elderly patient with hemiplegia is followed from admission to discharge.

Laboratory Diagnosis of Influenza

A 15-minute black and white film showing the step-by-step account of the isolation of influenza virus from the nose and throat washings of a patient.

These films may be rented by professional audiences, from: Canadian Film Institute, 1762 Carling Ave., Ottawa, 13, Ont.



NARISEPT

"DISPOSETTES"

SINGLE DOSE GENERAL PURPOSE ANTIBACTERIAL OINTMENT

A major break-through in the physician's effort to maintain sterile conditions and prevent undesirable sequelae in topical lesions has been made in the development of the new NARISEPT antibacterial ointment in handy "Disposettes" that eliminate the danger of re-infection from contaminated multiple dose containers.

Each "Disposette" (single-dose container) provides 900 mg. of ointment as—

Neomycin.....	3.5 mg.*
Bacitracin U.S.P.....	500 units
Anhydrous Petrolatum ointment base.....	q.s.
(*equivalent to Neomycin Sulfate U.S.P. 5 mg.)	

DIRECTIONS: Cut off soft, narrow spout-like tip and squeeze "Disposette" to direct ointment to affected area.

INDICATIONS: Use as a general purpose antibacterial ointment to prevent or treat infection such as may be encountered in abrasions, cuts, or minor burns or for nipple disinfection during breast feeding period. Also indicated for application on and around cartuncles and pimples.

HOSPITAL APPLICATIONS: Intranasally used as antiseptic, both in existing infection in the nose or in the destruction of organisms, as in asymptomatic nasal carriers.

PRESENTATION: 10 "Disposettes" in a unique sleeve type blister pack for one-at-a-time use.



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COLLEGE OF NURSES OF ONTARIO

Ontario's 40,000 registered nurses have elected 15 of their colleagues to be the first regional members of the Council of the College of Nurses of Ontario.

Elected regional members for the three-year term of office are: R. Catherine Aiken, (vice-president), and Sister M. St. Roch, London; Eileen Minty, Brantford; Jean K. Phillips, Shelburne; Margaret P. Morgan, Hamilton; M. Blanche Duncanson, Helen G. McArthur (president) and Gladys J. Sharpe, Toronto; Sister M. Benedicta, Peterborough; Sylvia M. Burkinshaw, Kingston; Grace Johnson, Ottawa; Sister St. Leonard, Sault Ste. Marie; Dorothy L. Adams, Fort William; M. Jennette Gillespie, Barrie; Madonna R. Richer, Timmins.

CALORIE CONSCIOUS ?

Are food combinations such as "grapefruit and hard-boiled eggs," "skim milk and bananas," formula diets, and "miracle" foods good reducing gimmicks?

These are only a few of the many "take off weight fast" diet plans. They all have one thing in common: they appeal to the imagination. Since the caloric content is low, weight will certainly be reduced. A drawback to most of these crash diets is that essential nutrients are lacking and if continued for more than a short period they may be dangerous to health.

The very monotony of these diets ensures that they will not be adhered to long enough to do any real harm, or for that matter to accomplish any effective or sustained weight loss.

Formula diets have been designed to provide all the nutrient requirements while still keeping the calorie intake at a low level. Experience has shown, however, that it is practically impossible to adhere to such a strict regime for too long a period.

The main concern with all these plans is that people following them learn nothing of proper food habits to ensure long-range weight control and health. When they "go off" their favorite fad they go right back to their original eating habits.

— *Canadian Nutrition Notes*,
Vol. 19, No. 6, June, 1963.

• • •

The man who makes no mistakes does not usually make anything. — E. J. PHELPS



effectively
replaces
the enema

DULCOLAX®

effectively replaces the enema

The patients' preference...

Dulcolax Suppositories do away with the physical discomfort and psychological embarrassment of the enema... produce a bowel evacuation within an hour. They have proven at least as effective, and often more effective than ordinary cleansing enemas.

The nurses' choice...

Dulcolax does away with the most unpleasant duty that nurses and ward personnel have—the routine administration of enemas. Dulcolax Suppositories save time, too—make it possible to complete all ward duties relative to bowel care by midmorning. And they eliminate frequent linen changes due to fecal soiling. Furthermore, there is no enema equipment to clean.

Dulcolax is available as Tablets 5 mg, Suppositories 10 mg, Suppositories for children 5 mg.



Boehringer Ingelheim Products
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B-5007-63

Blame Government, Not Pharmacist !

In any criticism of drug prices in Canada, it should be pointed out that:

1. The Government of Canada makes more money through its sales tax (11 per cent) on prescription drug sales than the pharmaceutical industry makes in net profit. For example, during the year ending January 1962, one company remitted, on behalf of patients, \$431,000 in Federal Sales Tax alone. This company's profit, after tax for the year amounted to \$333,000. A similar picture would relate to all companies engaged in the pharmaceutical industry.

2. Canada is the only country in the world to tax the sick for prescription medicine.

It would be interesting to know why the champions of cheaper drugs do not concentrate their ire where it could achieve the most good in the shortest time, namely on the Federal Government and its invidious sales tax!

— *News and Views*, Aug., 1963

* * *

Fluoride's Record

Winnipeg was one of the first major cities in Canada to add sodium fluoride to its water supply.

Now, after five years, the medical director of dental services for the city reports that only one six-year-old child in 50 needed teeth removed prematurely this year vs. seven out of 50 in 1959. He said the percentage of children in the group with cavities or decaying teeth in 1959 was about 75% vs. 45% this year.

— *The Financial Post*

* * *

Sick and Tired

After nursing in London hospitals for years, the writer is convinced that you can't beat the cockney for humor.

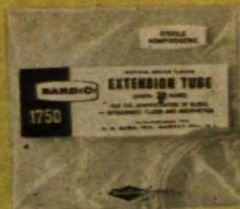
The patient in the bed next to Bill was forever grumbling and eventually Bill could stand it no longer.

"Look 'ere mate," he said, "if you 'ad Florence Nightingale 'erself to nurse you, you'd complain that 'er bloomin' lamp was smoking!" — *UNA Nursing Journal*, June, 1963.

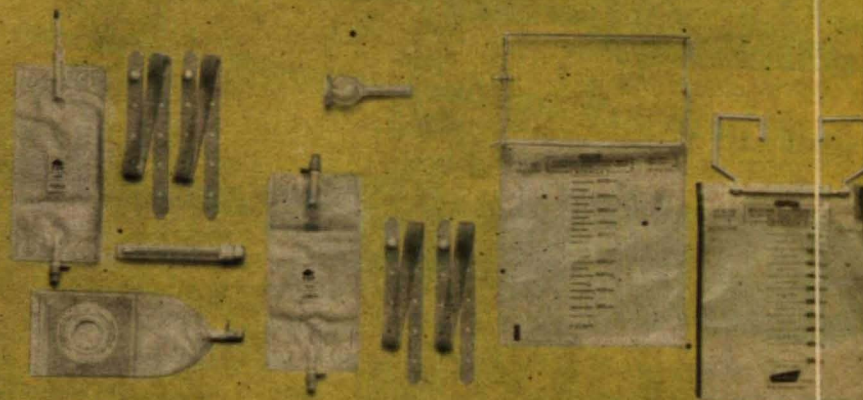
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Typical of BARDIC quality are the advantages of this No. 1750 Extension Tube: made of certified medical grade tubing, nonpyrogenic; packaged sterile inside and outside, full-flow lumen unrestricted at adapter connections; flexible, kink-resistant tubing.

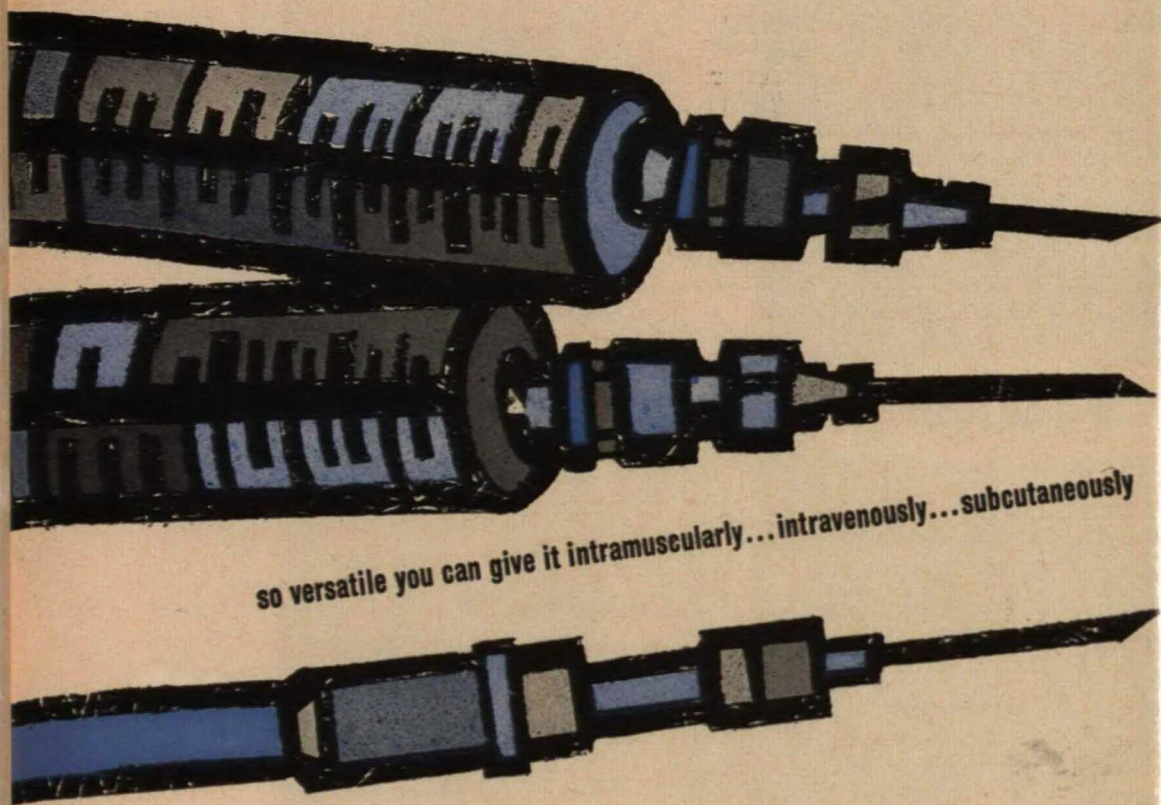
Other features of the BARDIC Line: bacteriostatic Urinary Drainage Tubes; smooth, precisely fabricated tips and eyes. Convenient packaging, too...easily opened plastic envelopes, lid-opening dispensing cartons.



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CHLOROMYCETIN Succinate offers the clinician a broad range of antimicrobial efficacy... provides rapid and effective blood and cerebrospinal fluid levels. It has been used successfully in Gram-positive and Gram-negative infections susceptible to

CHLOROMYCETIN—
such as *H. influenzae*

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CHLOROMYCETIN* Succinate

(chloramphenicol sodium succinate, Parke-Davis)

high tissue tolerance¹⁻³

CHLOROMYCETIN Succinate is extremely well tolerated; only minimal local reaction has been encountered at the site of injection. Even infants and young children showed "no induration, tenderness, or sloughing..." in spite of intensive intramuscular therapy for as long as 10 days.¹

ease of preparation

Highly soluble and easy to prepare as an aqueous solution, CHLOROMYCETIN Succinate can be administered alone or added to aqueous parenteral fluids. It is hydrolyzed rapidly in the body to the active form of the drug, and peak blood levels can be achieved within two hours after a single intramuscular dose.¹

Supplied: CHLOROMYCETIN Succinate (chloramphenicol sodium succinate, Parke-Davis) is supplied in Steri-Vials*, each containing the equivalent of 1 Gm. chloramphenicol; packages of 1 and 10.

CHLOROMYCETIN is also available in a variety of dosage forms for oral and topical use.

Warning: Serious and even fatal blood dyscrasias (aplastic anemia, hypoplastic anemia, thrombocytopenia, granulocytopenia) are known to occur after the administration of Chloramphenicol. Blood dyscrasias have occurred after short-term and prolonged therapy with this drug. Bearing in mind the possibility that such reactions may occur, Chloramphenicol should be used only for serious infections caused by organisms which are susceptible to its anti-bacterial effects. Chloramphenicol should not be used when other less potentially dangerous agents will be effective, or in the treatment of trivial infections such as colds, viral infections of the throat, or as a prophylactic agent.

Precautions: It is essential that adequate blood studies be made dur-

ing treatment with the drug. While blood studies may detect early peripheral blood changes such as leukopenia or granulocytopenia, before they become irreversible, such studies cannot be relied upon to detect bone marrow depression prior to development of aplastic anemia.

Chloramphenicol is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately, or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

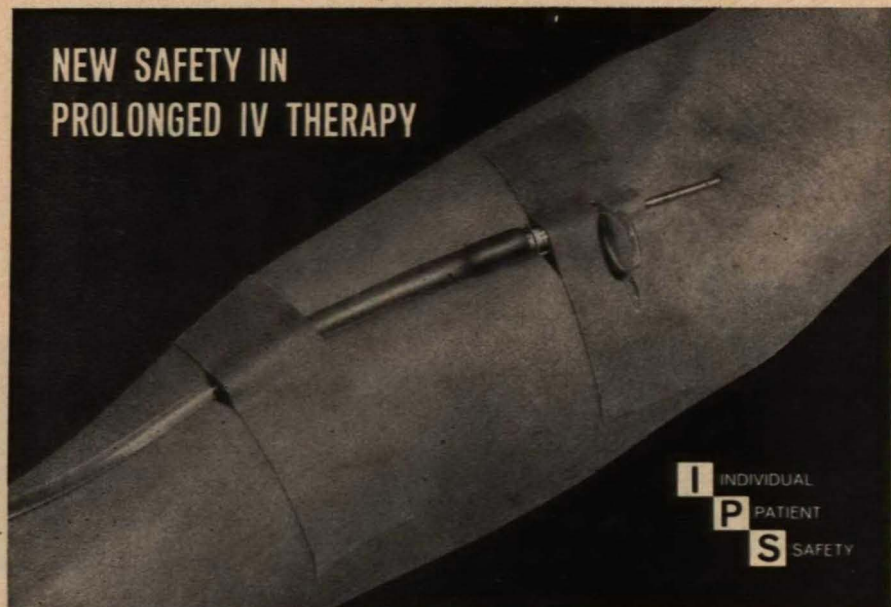
References: (1) Ross, S.; Puig, J. R., & Zaremba, E. A.: *Antibiotics Annual* 5:803, 1958. (2) McCrumb, F. R., Jr.; Snyder, M. J., & Hicken, W. J.: *ibid.*, p. 837. (3) Payne, H. M., & Hackney, R. L., Jr.: *ibid.*, p. 821.

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*Archives of Surgery 86:177 (Feb. 1963) "Accidental Loss of a Plastic Tube into Venous System," R. W. Taylor, M.D. & C. A. Rutherford, M.D.

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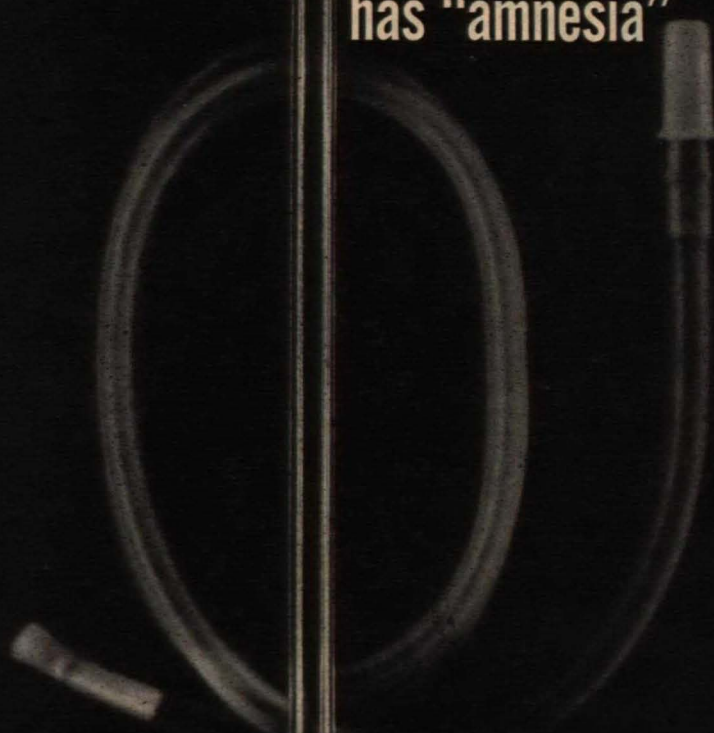
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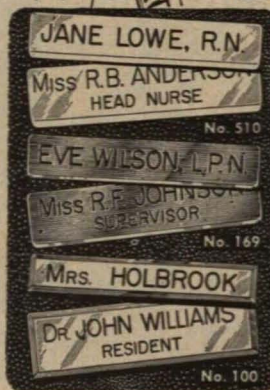
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Wound Infection

The results of a 27-month study of surgical procedures — including cystoscopies and other examinations carried out in the O.R. — are reported in *The Lancet*. A "significant association" was found between high surgical postoperative wound infection and late positioning of cases for the O.R.

Why? Three reasons, they conclude: 1. A breakdown of good aseptic techniques possibly due to natural fatigue of personnel; 2. an increase in contamination of the operating room theatre itself — walls, floors, air; or 3. the unconscious practice of placing the poor risk "clean" cases as well as the "dirty" cases later in the day, thus confusing the statistics. Interestingly enough, no association in sepsis rate was found between the duration of an operation, wound or drainage length, or advanced age of the patient.

— Squibb Nurses' Notes, vol. 12, July-Aug., 1963.

Health Problems

The incidence of some communicable diseases has decreased during the past decade; a few have become increasingly significant health problems.

The incidence of poliomyelitis dropped sharply since 1952. Diphtheria and whooping cough have diminished to a fraction of their incidence of a decade ago. The case rate for measles has not changed appreciably in level, but this most common of childhood infections is expected to fall off sharply in the near future with the mass scale use of recently developed vaccines.

Venereal diseases have not recorded the sharp reductions expected as a result of antibiotic therapy. In 1962, nearly 125,000 cases of syphilis and about 260,000 cases of gonorrhea were reported in the civilian population of the United States.

Two groups of diseases have shown erratic results in recent years: "The incidence of infectious and serum hepatitis rose steadily in the U.S.A. from less than 15,000 cases in 1957 to an all-time high of 72,500 cases in 1961. Last year, however, the trend was reversed and has continued downward this year. A rapid rise has occurred in the incidence of streptococcal sore throat and scarlet fever — from 73 per 100,000 population to more than double that rate in recent years. About a third of a million cases are now reported annually.

—Metropolitan Life Insurance Co.

* * *

Men do not understand books until they have had a certain amount of life, or at any rate no man understands a deep book, until he has seen and lived at least part of its contents.

— EZRA POUND

* * *

If life had a second edition, how I would correct the proofs!

— JOHN CLARE

ERRATUM

In the Nov. '63 *Journal*, Miss Patricia Bolitho, author of the article "Meniscotomy," was incorrectly listed as being instructor at the Vancouver General Hospital. This should have read: Miss Bolitho is Clinical Instructor (surgical) at the School of Nursing, Royal Inland Hospital, Kamloops, B.C.



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By AUDREY LATSHAW SUTTON, R.N., Formerly Instructor, H. Fletcher Brown Vocational School, Wilmington, Delaware. About 400 pages, 7- $\frac{1}{4}$ " x 10- $\frac{1}{4}$ ", with about 820 illustrations. About \$10.25.

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By MARTIN FROBISHER, Sc.D., Formerly Special Consultant, Laboratory Branch, Communicable Disease Center, U.S.P.H. Service; LUCILLE SOMMERMEYER, R.N., B.S., Ed.M., Professor in Nursing, Chairman of Department of Biological and Physical Sciences, Assistant Dean, Boston University School of Nursing; and ERNEST H. BLAUSTEIN, Ph.D., Professor of Biology, Boston University. About 560 pages, 6- $\frac{1}{8}$ " x 9- $\frac{1}{4}$ ", with about 260 illustrations. About \$7.25.

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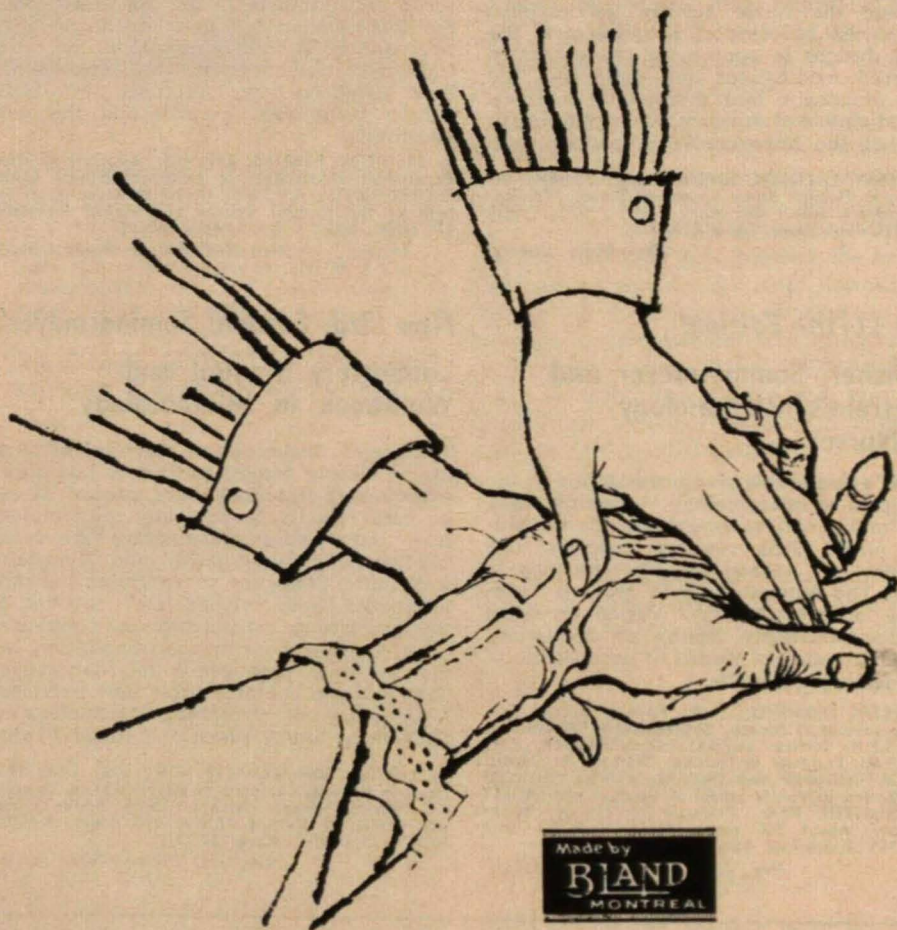
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BY THE CANADIAN NURSES' ASSOCIATION

VOLUME 59

MONTREAL, DECEMBER 1963

NUMBER 12

Optimism - it's contagious

Are you positive? Then you are spreading all around you a contagion that is good and highly desirable — the contagion of optimism. Optimism is derived from the Latin word *optimus* which means "the best." It is the inclination to put the most favorable construction upon actions and happenings or to anticipate the most favorable outcome. The communication and transmission of this positive approach to the minds and hearts of those whose lives we touch is an even greater benefit to mankind than the eradication of diseases which have plagued mankind for centuries. For it is an attack on the human problem — the problem of understanding man, his desires, his needs, his relationships with his fellow man and his Maker.

Man is a human being: physical, social, psychological and spiritual. When at his "optimum" he is in good

health but when at his worst he is a patient. A human being who is ill is upset and one who is upset is ill. The crying need is for the one who can help rebuild and bring out the "best" in this human being who is a patient — and avoid adding to the pain by a negative spirit. Tranquilizers, antibiotics, aseptic technique and vaccines are not enough. Our society demands for its members not merely the alleviation of pain and unhappiness but the creation of a positive, constructive state of health. The whole of our nursing care: our philosophy, our aims and objectives, our problem solving techniques, our treatments and our evaluations must be pervaded by optimism which is happily contagious.

Philosophically, in the last analysis, it is the individual that matters. Consider for a moment that Dr. Albert Schweitzer, now over ninety years of

Helen Creighton is Associate Professor of Nursing, University of Southwestern Louisiana, Lafayette, La.

Sister Catherine Armington, D.C. is Supervisor of Nursing Service, T.B. Annex, Lafayette Charity Hospital, Lafayette, La.

age and still providing medical treatment to the inhabitants of equatorial Africa, has by his teaching and example provided an answer which should give courage and hope to people. His rule for action he asserts as "reverence for life." Schweitzer says that such an attitude is civilization: the only progress in this world is growth in charity. It is a simple formula but simple things go deepest and to the extent people emulate Schweitzer they tend to master their current ordeal.

A positive, optimistic philosophy is grounded on things that endure and give meaning to life¹. Faith is the "driving motor of life," the "clue of reality" and the "medicine of care." This faith must be grounded on a religious attitude. As the prophet Micha stated: "You have been told, O man, what is good and what the Lord requires of you: only, to do the right, and to love goodness and to walk humbly with your God."² A positive, optimistic philosophy requires vision—the outlook expressed by St. Paul when he said: "For the rest, brethren, whatever things are true, whatever honorable, whatever just, whatever holy, whatever lovable, whatever of good repute, if there be any virtue, if anything worthy of praise, think upon these things."³

Think upon these things . . . It has been said that if we do not act the way we think, we'll soon be thinking the way we act. So the vision required in an optimistic philosophy of life must be personal — but it must be our "optimum" — our "best" — and it must bring out the best in others. A positive optimistic philosophy requires courage to implement it.

The Christopher's motto, "You can change the world" is one of dynamic action directed to positive end values. Such a philosophy or spirit, recognizing the unique worth of every person, encourages the patient whatever his diagnosis and prognosis may be. It takes courage to "light the candle instead of cursing the darkness."

In our aims and objectives of nursing care, optimism consists of a positive approach which is nonetheless a realistic one. We recognize that in working together with our medical colleagues toward the care of the whole

patient, sometimes we can cure them, generally we can help them, but always we can comfort them. Sister Olivia's definition of our work is at once constructive and optimistic: "Nursing in its broadest sense may be defined as an art and a science which involves the whole patient — body, mind and spirit: promotes his spiritual, mental and physical health by teaching and example; stresses health education and health preservation, as well as ministration to the sick; involves the care of the patient's environment — social and spiritual as well as physical; and gives health service to the family and community as well as to the individual."⁴ If these are the goals of nursing, then the function of nurses is the act of doing or carrying them into effect. As we proceed with our activities we transmit our philosophy and objectives to our patient, family, co-workers and the surrounding community.

Essentially we carry out nursing care leading to one of five goals:

1. Through health teaching we prevent much illness and numerous accidents as in our pre- and postnatal teaching of mothers and well baby clinics, our nutritional teaching, immunization and accident prevention programs.

2. We assist the patient to obtain a cure when cure is possible with current medical science or surgery. For example, the patient with appendicitis is cured by an appendectomy.

3. We strive through patient teaching plus the administration of the care toward the goal of successful maintenance, as in the diabetic or cardiac medical patient. No longer need the individual's outlook be dismal and severely restricted but rather with moderation, discretion and following planned care he may look forward to a normal, useful and happy life.

4. We are engaged with our patient in the function of restoration; this is the goal in rehabilitation work, as in the care of a hemiplegic patient. We know that 90 per cent of those who survive a stroke may again become independent in activities of daily living and our care is enthusiastically directed to the realization of such restoration.

5. Our nursing care may be directed toward acceptance as in the case of a patient with terminal cancer.

Perchance some nurses may themselves need to evolve a philosophy of acceptance in order to approach death with optimism. Ours is a youth oriented country; in secular life we are mainly oriented to a "non-death" society — witness the liberal use of intravenous fluids, adrenalin, cardiac massage and other measures to force people to live. Yet, if we think about this whole business of living and dying we realize that life here is but an inch compared to all the miles of eternity. We remind ourselves that we are going to live for all eternity. If we believe in God, if we believe in and strive for an everlasting life with Him, then death is not so much an event which is the end of things but the beginning of real life. Thus viewed we look forward to death with respectful planning and optimism.

We can assist our patients to achieve acceptance through providing sick people with the opportunity to express themselves in prayer and making available an appropriate chaplain in time of need . . . and a prayer of our own for all under our care.

Concerning the social and psychological needs of people, we can foster more positive attitudes toward these through a sense of security within ourselves and a spirit of quiet joy in living. Patients want a team spirit and a feeling of being accepted and belonging which we can foster. It is worth noting that psychological security is not physical — a matter of armaments, nor wealth, contracts, government pensions, political promises nor yet freedom from fear. Though we travel the world over to find security, we must carry it with us or we find it not; security lies within us and in our hearts. Security radiates from inside out — not the reverse — and depends on our behavior toward society and its acceptance of us. If we as nurses develop such a sense of security we can help our patients and all others who contact us to do the same; again, security produces an optimism towards life that is contagious.

A quiet joy in living adds to our personal optimism and to that of those around us. A quotation from "The Joy Makers" states:

There are souls in the world who have

the gift of finding joy everywhere and leaving it behind them where they go. Joy gushes from their fingers like jets of light. Their influence is an inevitable gladdening of the heart.

We cannot always explain why these people are so pleasant. They may not be robust, they may not be particularly witty or superior intellectually and they may have heavy burdens on their hearts. Yet, they make a dull day cheerful and have somewhat the same effect on a room as an open fire or an arrangement of colorful spring flowers — they make us feel pleasant for the time because they are. Such pleasantness and optimism is a happy contagion that eases any pain.

It is important, too, to be optimistic in our evaluations. There is considerable truth to the old adage that a man finds what he seeks. There are positive factors in every situation; there is something good in everyone. As the poet said: "Two men looked out through prison bars; one saw the mud, the other the stars."

We must look for the stars, look on the brighter side of things. This requires understanding. Understanding is the reward of faith. It requires much faith, considerable vision and a generous supply of courage to be optimistic. May we be granted the wisdom to comprehend, the courage to endure and the grace to sweeten the business of life with optimism — and it is contagious.

HELEN CREIGHTON, M.A., J.D.
and

SISTER CATHERINE ARMINGTON,
D.C., B.S.N.E.

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An Active Treatment Geriatric Ward

DIANE INGLIS and L. ALLISON SAYERS

An account of the nursing care provided for geriatric patients at The Toronto Western Hospital.

Over the past 300 years, the life expectancy of man in our society has increased from approximately 27.5 to 70 years. This has far-reaching implications as far as social welfare planning, medical and nursing care are concerned. Some questions that arise are: How well are we equipped mentally, socially and psychologically to live a longer life? How well prepared are we to care for those who are presently living beyond the Biblical "three score years and ten?" How much and what kind of care do they require as a group?

Prompted by questions such as these, a group of doctors from Toronto Western Hospital and Metropolitan Toronto Department of Welfare consulted together. One result was a decision to establish a ward at TWH that would serve as an acute treatment centre for residents of the Metropolitan Toronto Homes for the Aged, or, if beds were available, for private and semi-private patients over 65 years of age. The construction of the 42-bed ward which was opened in April, 1961, was financed by the Department of Welfare but it is under the administration of the hospital.

This modern hospital ward of 2- and 4-bed rooms has been specially constructed and furnished for the geriatric patient.

1. Bathrooms off each room have extra wide doors to facilitate passage of wheel chairs.

Mrs. Inglis is the head nurse and Miss Sayers an instructor on the special geriatric ward of the Toronto Western Hospital.

2. Since safety is such an important factor, all beds are equipped with full length side rails. These also provide a brace or support that enables the patient to move about easily.

3. "Hi-lo" beds are used to enable the up-patient to get in and out of bed with more safety and ease.

4. To facilitate bathing, a large tub room has been equipped with an elevated bath tub accessible from both sides and one end, and two sitz-baths with temperature-controlled water faucets.

5. Alarm buttons have been installed in all patients' bathrooms and beside each utility in the tub room.

6. Handrails along the corridor walls and in bathrooms facilitate ambulation and encourage the patient to be independent.

7. A central lounge, equipped with a television set, large comfortable chairs and two large tables promotes group activities and sociability, necessary to combat the tendency of some patients to be depressed and passive.

VISITING HOURS

Although visiting hours are fairly flexible, they are officially between the hours of 2:00 - 4:00 p.m. and 7:00 - 9:00 p.m. Since many of the visitors are friends in the same age group and may have come a great distance, the afternoon hours are the most practical for them. Because visits from old friends have a therapeutic value, the usual visiting hours are relaxed as much as possible.

VOLUNTEERS

Have you ever sat and talked with a person born in another century? This

is a rewarding experience. Most nurses would enjoy spending more time chatting to their patients but the pressure of nursing duties leaves them with limited time. The morning bath and treatment period is not long enough to create a relationship that will help the patient to establish an interest in life and a desire to get well. Volunteers who will come and spend a few hours just talking to patients, feeding them or taking them to visit the gift shop or lounges in other parts of the hospital are a necessity. Those who work with geriatric patients derive a great deal of satisfaction from the simple joy of human contact. The value to the patient is inestimable. Volunteers are encouraged for this service.

PSYCHOLOGICAL ASPECTS

The attitudes of the nurses, doctors and other staff members on a geriatric ward are extremely important. An interest in older people and an appreciation of the challenges to be faced in their care are essential. Loneliness or a feeling of being unwanted or useless often plague the elderly individual. How can the nurse help him to maintain or to regain his sense of personal worth? Basically, she must admire sincerely and listen attentively. There is always something special about her patient: his cards or flowers; the twinkle in his eye; his rugged individuality. Everyone appreciates a complimentary word as long as it is sincere.

Listening is an art that must be developed. The experience of talking to someone who is physically present but who, in his thoughts, is "a million miles away," is a common one. The geriatric nurse should never be guilty of this. She should try to discern not only what her patient says, but what he means or what he has left unsaid.

The nurse must make judgments for the aged patient and decide what is dangerous and what is harmless. The senile patient should be allowed freedom; he should not be restrained, emotionally or physically, unless there is danger to himself or others. It takes skill and experience to make judicious decisions of this type.

Personal characteristics change only slightly with age; some become more

exaggerated, others become less apparent. The individual who, in youth, was kind and thoughtful, or critical and selfish will remain so throughout his life. This fact has implications in the nursing care of the elderly.

Older people, unlike younger people, do not have the same desire to conform. It can be very discouraging in hospital to try to set up a social group only to find that the older people do not feel compelled to make friends or to be sociable just because we want them to be. Their friends are at the home from which they have come, and to which they hope to return soon. There is often no interest in temporary friendships. Common sense must be displayed in attempting to interest the older patient in suitable activities.

NURSING CARE

Nursing care must, of necessity, have special emphasis in geriatrics. On our unit a six-point plan for the physical nursing care of patients emphasizes the following:

1. Nutrition
2. Skin care
3. Mouth care
4. Elimination
5. Ventilation
6. Ambulation

All nurses are aware of the importance of these factors, but awareness is not enough. They must be put into practice with thoughtfulness and planning.

Nutrition

Nutrition is important at any age, but with the elderly physical and mental deterioration can occur very rapidly if the intake of food and fluid is inadequate. Everyone has heard of the traditional "tea and toast" diet attributed to the old person living alone. Emphasis must be placed on adequate food nutrients to provide a well-balanced diet. After consideration of this and of the fact that food must be easy to chew and digest, the great emphasis is on fluid intake. The older person who becomes dehydrated, in addition to his physical symptoms, frequently has the added problem of mental cloudiness for which he may easily be labelled "senile." Dramatic

changes can occur with adequate fluid intake and improved nutrition. With most patients, the aim is to maintain a 2,000 cc. fluid intake over a 24-hour period. This involves patience and perseverance as well as team work. If a patient can tolerate only a few sips of fluid at any one time, it is necessary to offer him small amounts of fluid more frequently. When medications are given, instead of just enough fluid to swallow the tablet, a full glass of beverage is given. The importance of *offering* fluids frequently cannot be over-emphasized. Many elderly patients are unwilling or unable to reach for the glass at the bedside.

Some methods or approaches that have proved helpful in encouraging patients to drink are:

- Use of a glass or cup;
- allow or assist the patient to hold the cup or glass, if possible;
- see that the patient is sitting or is in a comfortable supported position;
- discover the patient's likes and dislikes concerning beverages and make use of this information.

Discourage:

- Use of drinking straws which seem to increase the amount of air swallowed and may lead to gaseous distention;
- use of syringes for "forcing" fluids since this may lead to aspiration of fluid.

Since fluid intake by the oral or natural route is emphasized, it is rarely necessary to resort to intravenous administration or duodenal feeding to maintain hydration. Oral fluids are the best way to

- keep the mouth clean and healthy;
- aid bowel regularity;
- irrigate the urinary system.

Skin Care

In nursing any sick patient care of the skin is important. It requires special emphasis in the care of geriatric patients due to physiological changes such as loss of subcutaneous tissue, dryness of the skin and general wasting of muscle.

Emphasis is constantly placed on the prevention of decubiti. With adequate cleansing, using soap and water liberally and drying thoroughly, proper positioning, frequent turning and mas-

sage, there is no problem. Devices such as air-rings and "do-nuts" are not recommended or used because they often cause further pressure areas and may tend to give a false sense of security. Cellulose tape is more satisfactory for the sensitive skin of the older person than is adhesive tape when dressings must be held in place. Rubbing alcohol and powder are an unsuitable combination for skin care. Both tend to be drying; the alcohol does not facilitate adequate massage; the powder tends to collect in loose tissue folds. The most effective "back-rub," presently in routine use, is maize oil and alcohol in proportions 1:1. This mixture helps to keep skin well-lubricated and, in conjunction with gentle prolonged massage to the back and all pressure points, contributes to a healthy, intact skin. Occasionally, patients have special skin problems and these require medical attention.

Mouth Care

No physical examination would be complete without an inspection of the mouth including the condition of the tongue. One of the first signs of dehydration, malnutrition, general debility or other disease conditions is a "coated" tongue. Parotitis, often cited as a complication that may occur if good oral hygiene is not maintained, may lead to termination of life for the older patient. Excellent oral hygiene must be maintained since, in geriatrics, even mouth care can be a life and death matter.

Elimination

Bladder: As far as possible, a normal bathroom routine is encouraged for all patients. With frequent, regular panning and prompt attention to the bed-patient's call, the problem of incontinence is minimized.

Indwelling urinary catheters are used only for urological or medical reasons, not as a convenience to facilitate the nursing care of an incontinent patient. With the older patient, who may be confused or senile, there is not only the inherent danger of genitourinary infection but also of actual physical damage to the bladder neck because

of pulling. In addition there is the mental distress of an "unnatural" method of voiding. When indwelling urinary catheters are used, they are changed weekly and irrigated daily, unless contraindicated. Observations are made by the nurse regarding the appearance and amount of urine voided during each period of duty.

Accurate records of fluid intake and output are very essential to help assess whether there is fluid retention, either in the bladder or in the tissues. Because of decreased sensation and loss of bladder tone, an enlarged prostate gland in male patients, and various gynecological problems in female patients, there is a greater tendency to retain fluid in the bladder. Encouragement of a regular voiding habit can be helpful.

Bowel: Much has been written regarding the physical and psychological means of obtaining and maintaining regularity of bowel function. Basically, the general precepts of bowel hygiene are followed. With the older person, however, it is necessary to resort to the use of oral laxatives, suppositories, oil retention and other types of enemas.

Constipation in the healthy elderly person is frequently a problem. The motor and muscular activity of the bowel decreases with age; the nerve sensations are less acute and the signal for bowel elimination may be missed; the diet may not contain a proper balance of bulk and soft foods; the activity of the individual may lessen. With illness, activity is affected and diet may be faulty resulting in impaction as well as constipation. At the end of her period of duty each nurse must carefully record the number and type of bowel movements her patients have had. After two days, if a patient has not had a movement, a mild laxative is given. If the laxative does not prove effective by the next morning, the patient is given an enema or a suppository. The most commonly used solution at the present time is the commercially prepared type.

In our experience the combination of careful observation and supervision of bowel elimination, fluid intake and exercise has proved satisfactory in

the maintenance of regular bowel elimination.

Ventilation

Older people usually do not enjoy fresh, cool air. They prefer the warmth and coziness of a stuffier environment. They are more susceptible to draughts and to chilling because of physiological changes such as loss of adipose tissue and decreased circulatory effectiveness. Despite these factors, it is necessary to have adequate ventilation of the ward.

Our geriatric ward is equipped with air conditioning that is of great help during the warm months. Aerosol sprays are used sparingly in conjunction with the daily practice of airing the rooms. After the morning bath when the patient is comfortably ensconced in the lounge or covered warmly in bed or in a chair in his room, windows are opened and the rooms are aired thoroughly. This practice seems to be effective in creating a pleasant lunch-time atmosphere.

Ambulation

In its broadest sense, ambulation implies any movement or walking done by the individual. The value of early ambulation for patients of all age groups has been generally accepted. With the geriatric patient, however, it is not only recommended but vital to his physical and mental well-being. If the older patient is kept in bed, he soon shows undesirable physical complications such as pneumonia, thrombosis, contractures, pressure areas, mental depression, disinterest and deterioration. Every older patient should be up in a chair or walking at least once a day unless he is in the acute stages of coronary thrombosis, pneumonia or pulmonary embolism.

Ambulation serves as a mental as well as a physical stimulant and increases the individual's interest in the world around him.

ORGANIZATION

Medical Staff: The medical staff operates under the direction of a geriatric committee composed of: The medical director of the hospital, an

internist, an orthopedic surgeon, a urologist and a gynecologist. The direct representative of this committee on the ward is a Fellow in geriatrics. As part of his experience within the department of medicine, one assistant resident rotates to the geriatric unit for 12 weeks and three medical junior interns come for four weeks' experience. Patients are admitted directly to the geriatric service and personnel from other specialized services within the hospital act as consultants.

Physiotherapist: One physiotherapist with the help of a student gives active and passive exercises as prescribed by the doctor. She works in cooperation with the medical and nursing staff and is available for consultation regarding ambulation problems or other difficulties.

Nursing Staff: Careful selection of the nursing staff is essential. Nurses must have a sincere fondness and desire to care for the older patient. They must be mature, flexible and patient. Their powers of observation must be keen; they require a well-developed sense of humor. When each nurse has these attributes, the total staff functions together as a team and maintains an *esprit de corps* that facilitates and enhances the quality of nursing care.

The staff consists of a head nurse, an assistant, six general staff nurses, eight female and three male nursing assistants, and a ward clerk. Six nurse internes are assigned for eight weeks' experience. The nurse internes are third year students who have completed the theory and practice of the first two years of their course and are receiving practical experience in the third year. They function as junior staff members. This appears to be a large staff but it has proved necessary in view of the variety and severity of the illnesses and the complications, which inevitably arise in this age group.

After the ward had been in operation for one year and was functioning smoothly and efficiently, the time seemed appropriate to assign students to the area. Because of the more comprehensive care required by geriatric patients, it was recognized that the ward did not lend itself as well to first-year

student experience. The current rotation plan makes provision for every student, in groups of five to eight, to spend four weeks on this ward during her second year medical-surgical nursing experience. Students attend a one-hour clinic daily and are prepared to discuss the particular requirements of their patients together with methods of providing the much-needed psychological support. In addition, emphasis is placed on the numerous problems encountered in nursing the elderly, the long-term patient, and the aged person in the community. An afternoon visit is arranged to one of the Ontario Department of Welfare homes, where students see some of the community services in action and gain an appreciation of the health team and the importance of good working relationships among all those who contribute toward better patient care in hospital and community.

Team Nursing: Because of the emphasis that must be placed on "basic nursing care," the most effective plan for this large ward has proved to be team nursing. The end result has been better patient care.

For the day period, there are two team leaders, each responsible for the patients on one-half of the ward. The leaders are registered nurses who have no specific patient assignment. This may sound extravagant in terms of nursing staff but it must be remembered that these patients are acutely ill and require expert care. Team leaders are responsible for all nursing care given to their respective patients and for efficient functioning of their team members, under the supervision of the head nurse or her assistant.

When team leaders have no specific patient assignment they have more time to offer help or supervision to individual team members. Each is responsible for:

- Administering 8:00 a.m. medications to the patients; keeping an adequate medicine supply for her patients for the 24-hour period;

- charting all medications and treatments for the nursing assistants on her team;

- accompanying and supervising the male nursing assistants who lift the patients into chairs or weigh them on a bed scale;

making out the patient assignment for the team members for the following day, keeping in mind the needs of the patients and the individual abilities and capabilities of the team members. Student assignments are planned by the clinical instructor;

conducting a daily team conference to discuss any special patient needs;

making rounds with the charge nurse in the afternoon following the team conference. This enables the team leader to receive direct supervision from the head nurse and also ensures that the head nurse obtains a complete report on all of the patients. A more accurate, detailed and pertinent report can then be given by the head nurse to the evening staff.

This method of team nursing has proved an incentive to graduate staff and has helped to hold their interest. They appreciate the opportunity to accept the responsibility for the nursing care given; they enjoy having a specific patient assignment as a change in routine. The team members find this system helpful because their team leader is available to help them with any difficult situations.

It is essential that the head nurse and her assistant should make daily morning rounds. This gives them an opportunity to see and to talk with the patients and to learn their specific needs and problems. They check patients' backs, pressure points, mouths and any dressings or problem areas. In this way, they assess the nursing care being given and offer appropriate

suggestions for more effective care. The suggestions are made to the team leader who passes them on to the team member who can put them into practice.

CONCLUSION

Since the geriatric ward has been functioning, it has proved advantageous for the patient and for those caring for him. In place of custodial care the patient benefits from the most skilled medical and surgical treatment that modern science can devise. Due to earlier admission which is the result of cooperation and planning by the medical staff of the hospital and of the home for the aged, the older patient receives prompt investigation and treatment. A staff that understands the signs of impending complications can usually minimize the acuteness of the illness. The possibility of readmission to hospital is three times as great with the aged person. He tolerates change poorly and therefore it is advantageous to have him return to a familiar environment.

The ward has advantages for medical interns, nurse internes and student nurses, as well as for senior professional staff since it offers opportunities to observe concepts in geriatric care. As a possible result of this, the geriatric patient of the future may be viewed with enthusiasm and hope rather than with disinterest and distaste.

A Trend of Our Time

The growing popularity of apartments can be attributed to a variety of factors, some of which are related to the increased mobility of the population. For example, the practice among some large companies of moving administrative employees from one city to another no doubt discourages many families from investing in a home. In addition, it would appear that the cost and time of transportation and the desire to take advantage of the social and cultural facilities provided by the city have to some extent offset the appeal of life in the suburbs.

Perhaps the most important factor, however, has been a population mix that favors apartment living. Apartments are best suited, both in terms of space and cost, to young families with no children or only one child, older couples whose children are no longer living at home, and non-family households. During the fifties the number of households belonging to these categories grew rapidly and this trend is likely to continue for several years.

— *Bank of Montreal Business Review*, May 31, 1963.

ACUTE TREATMENT FOR GERIATRIC PATIENTS

E. EARLE BROWN, M.D.

A pioneer program in geriatric care in a special ward in a general hospital.

Although the integrated and comprehensive care of individual residents is the ultimate goal of every geriatric program, its realization is not always easy in welfare homes because of limited facilities and/or budgets. Fragmentation is especially likely to occur in large metropolitan areas where the acutely ill geriatric patient must be admitted to whatever hospital has an available bed. Certain authorities in Toronto felt that one ward with ready access to investigative and therapeutic procedures would have very definite advantages for the geriatric patient, the professional staff on the ward and the City Welfare Department, as well as permit collection of valuable clinical data.

Through the cooperation and financial support of the Ontario Department of Welfare, a 42-bed unit in The Toronto Western Hospital was built and equipped especially for the geriatric patient. It functions as the second phase of a total care program that can be broken down into four phases:

Domiciliary care of the well individual;
intensive treatment of the acutely ill;
supervised convalescent care; care of the chronically ill.

Over 90 per cent of the patients are admitted from the Metropolitan Welfare Homes for the Aged or from low rental housing developments for senior

citizens. The admissions are of two types: direct from the home as an emergency, or on an elective basis with a preliminary assessment carried out in the central geriatric centre by one of the 14 geriatric consultants, most of whom are on the teaching staff of the hospital.

The analysis of the first two years of operation have produced many figures, charts and facts that are interesting and valuable but are not an entirely adequate appraisal of the benefits of the ward. A few relevant facts have been picked from these general statistics following which a single group of patients will be reviewed in more detail to illustrate the experience of the ward.

The total number of admissions in the first two years to this 42-bed ward was 1008 patients. Simple division produces an average stay in hospital of 27.5 days per patient. This is somewhat longer than anticipated but the third phase of the program — the convalescent hospital — was not in full operation. Because the patient was transferred back directly to domiciliary care, he was kept for a period of convalescence.

The precipitating causes of admission for the first 487 patients are listed according to the International List Classification System.

Diseases of the gastrointestinal tract are at the top of the list. From our experience the ratio of duodenal to gastric ulcers present in younger people, does not hold true in this age group.

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of alimentary tract	72
of urinary tract	71
of cardiovascular system	60
of respiratory system	43
Fractures	40
of male genital tract	33
of eye	23
of hematopoietic system	23
of nervous system	21
of female genital system	19
of skin	18
of liver and gall bladder	18
of endocrine glands	13
of bone	11
of joints	9
Neuroses and psychoses	7
Errors in metabolism	4
Collagen diseases	2
Total	487

of cardiovascular system	64
of hematopoietic system	48
of endocrine glands	37
of urinary tract	36
of nervous system	30
of alimentary tract	21
of respiratory system	15
of male genital tract	14
of joints	10
of eye	6
of liver and gall bladder	6
of bone	6
of skin	5
Errors in metabolism	1
Total	299

Patients with coronaries, cerebrovascular accidents or congestive heart failure were usually admitted only if they required oxygen, intravenous therapy, investigation or extensive physiotherapy and, of course, this affects the series somewhat. More meaningful data are obtained when these general categories are broken down into specific disease entities and the patterns become apparent.

As might be expected, many of these patients had evidence of other major chronic illnesses. Using the same system, the second list tabulates associated diseases. Not surprisingly, symptomatic ischemic and hypertensive heart disease head the list.

For a more detailed examination, the series of fractured femurs or hips has been chosen. Before presenting the actual figures, it should be noted that at The Toronto Western Hospital all pa-

tients with fractured hips are taken to the surgical x-ray room, anesthetized, and under direct fluoroscopic vision, a pin is inserted along a guide wire. The patient is then transferred to the operating room for further internal fixation in the form of a plate and screw nails. This two-stage technique is relatively uncommon and it has obvious disadvantages but the two important advantages include better fixation and a reduced time under anesthesia.

There were 69 patients in the first 22 months with an over-all average age of 82.7 years — somewhat higher than for most series! The average age of the 13 deaths was even more striking — 87.5 years. The comparative figures are from series published from Queen Centre Hospital, Jamaica, N.Y., in 1961 and from Buffalo, N.Y., in 1956. The average age — 73.4 years — is considerably lower, as it was in our own hospital during the same period of time for all private and public cases *not on the geriatric floor*. The 19% mortality rate compares favorably

TABLE I

	Toronto	Jamaica, N.Y.	Buffalo, N.Y.
Total number of patients	69 M - 17 F - 52	426	119
Number of deaths in hospital	13		
Mortality rate in hospital	19%	23%	25.6%
Average age of all patients	82.7 yrs.	75	73
Average age of survivors	81.5 yrs.		
Average age of deceased	87.5 yrs.		
Average time between fracture and repair	26.8 hrs.	7.3 days	5.4 days
Type of Fracture			
Intertrochanteric		44 patients	
Transcervical		10 patients	
Subcapital		15 patients	

with the two other series. There seems to be general agreement that all patients with fractured hips should be treated as emergencies and definitive surgical fixation carried out as quickly as possible. As the length of time between the fracture and fixation increases, so do fatal complications and morbidity.

As a general rule, intertrochanteric fractures were treated with a pin and plate, as the table indicates. These

an uncooperative senile patient cannot be ignored. These patients are given intensive physiotherapy and remain in hospital until they have reached what appears to be their maximum degree of ambulation.

The number of complications encountered in only 69 patients is staggering and illustrates better than words some of the problems presented. Included as a complication is senility where patients were unable or un-

TABLE II

Type of Fixation

<i>Type of repair</i>	<i>No. of patients</i>	<i>Aver. ansth. time</i>	<i>Aver. days in hospital</i>	<i>No. deaths in hospital</i>
Pin only	16	56 min.	21	2
Pin and Plate	42	102 min.	25	10
Moore Arthroplasty	8	90 min.	49	—
Pin and Moore Arthroplasty	2	—	90	1
Impaction Treatment	1	—	26	—

patients sat in a chair the next day but were not allowed to weight-bear until there was radiological evidence of good callous formation — usually in 12 — 16 weeks. This group had the longest anesthetic time, but in our series this correlated poorly with their complications. However, this does not mean that the duration and type of anesthetic is not important. The stay in hospital is usually about 14 — 16 days in the uncomplicated cases, but the average shown is higher because a few patients had severe complications and were in 45 — 80 days. They returned to the domiciliary care home where they are lifted in and out of bed but are not allowed to weight-bear. When callous formation is adequate they may be readmitted for a two-week period of intensive physiotherapy.

Most transcervical and some sub-capital fractures were treated with a pin only. This decision was influenced by the general condition of the patient and whether he had been ambulant before or not. The management in hospital was the same as outlined for the intertrochanteric fracture.

As is most centres, Moore arthroplasties are becoming more popular and the fact that only eight were performed is a reflection on the type of patient. The risks involved in complete bed rest for at least 14 days of

willing to cooperate in deep breathing or exercises; unwilling to eat or drink; frequently incontinent of bowel or bladder. Approximately 50 per cent of the patients were in this category.

All patients except those whose fixation was a pin only, received 500-1500 cc. of blood during operation and in the first two or three postoperative days. Antibiotics were used only as required and not prophylactically. Digitalization was carried out at any time that there was the slightest indication of need.

Complications with Fractured Hips

Confusion state temporary or permanent	31
Urinary tract infection	12
Pneumonia - mild to severe	10
Decubitus ulcer	7
Congestive heart failure	4
Wound infection	3
Pulmonary emboli	3
Iron deficiency anemia	2
Myocardial infarction	2
Dehydration	1
Drug rash	1
Cardiovascular accident	1
Parotitis	1

Considering the physical and mental status of many of the patients, the "hospital results" are gratifying. However, the ultimate goal of any treat-

TABLE III

<i>Cause of death</i>	<i>No. of patients</i>	<i>Day of death</i>
Bilateral acute bronchopneumonia	4	11; 79; 4; 8
Pulmonary emboli	3	28; 1; 21
Myocardial infarction	2	28; 1
Septicemia from infected operative site	2	18; 51
Sudden unexplained death — negative autopsy	3	12; 3; 3

ment is to return the patient to his previous level of health, that is, to a fully ambulant state when this is possible. The long-term follow-up statistics are as important as the immediate results. Already some of the figures are striking. Utilizing only the data from those patients treated in the first 18 months, 40 residents were returned to domiciliary care. Reviewing these patients 6 - 24 months following discharge, only 26 are still living. The 14 deaths occurred in the markedly senile patients, mostly within the first 6 months. The causes of death most frequently listed are bronchopneumonia, dehydration and arteriosclerotic heart disease. Of the remaining 26 patients:

- 17 were fully ambulant before surgery;
- 7 were partially ambulant before surgery;
- 2 were confined entirely to wheel chairs.

Following surgery,

- 10 are fully ambulant;
- 13 are partially ambulant;
- 3 are confined to wheel chairs.

It is expected that some of the partially ambulant residents will become fully ambulant.

From these results it would appear that these senile patients might benefit from a further period of supervised nursing care and intensive physiotherapy. More personalized care is needed than a domiciliary home can be expected to give, but not as much as an acute treatment unit offers. Consequently, the intermediate phase, or convalescent unit, becomes important. It is important and practical in another way. Although the person's welfare is the main consideration, the economic feasibility of any program must always be considered. It is worth noting that in Ontario the cost per day per patient in the acute treatment bed is 5 - 8 times the cost of domiciliary care, while in the convalescent hospital, the cost of care is 2 - 2.5 times the cost of a domiciliary bed.

Summary

The acute treatment unit produces varied advantages depending upon the nature of the geriatric program in the individual community. The patient benefits by admission in the earlier stages of an acute illness when a few hours saved in the beginning may reduce his convalescence by days. Investigation, evaluation, and prompt treatment are simplified when laboratory and x-ray facilities as well as skilled technicians are readily available. Intensive care is made easier when the team consisting of nurse, physiotherapist, physician and others deal exclusively with the geriatric patient. There is no doubt that impending complications are anticipated more readily and therapeutic measures instituted with greater speed.

Another advantage for the patient is of increasing significance. Everyone is aware of how poorly the aged tolerate a change in their environment. A pleasant, mildly confused individual will often become openly hostile and paranoid in the first few days in a hospital. Since readmission in this age group is so frequent, it is an advantage to have the patient returned each time to a familiar environment where she is surrounded by at least a few of her acquaintances.

The ward has another very important function, education through association and research. Student and graduate nurses, medical students and interns are exposed to the ever-increasing geriatric problems — socio-economic, psychological and medical. Finally, the Department of Welfare itself derives certain benefits. Earlier admission and intensive care frequently mean earlier discharge from an active treatment bed which is synonymous with an expensive bed in a general hospital. Administration at all levels is facilitated when patients are being admitted and discharged from one location.

The acute treatment ward should

be the second phase of a closely coordinated program to which patients are admitted rapidly from domiciliary care in the early stages of their illness. In this unit, they receive a series of correlated, integrated, scientific appraisals which are aimed at diagnosis and curative therapy. It is not meant to serve

as a rehabilitation centre because this would make costly hospital beds unavailable for other use for too long a period. Supervised convalescent care which is equally important must be continued in a less costly location than a general hospital if this program is to remain financially practical.

How Long Will You Keep Your Teeth?

J. D. STEWART, B.SC. D.D.S.

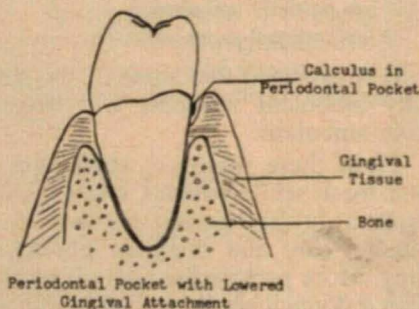
Statistics tell us that 70 per cent of all adults will lose their teeth because of periodontal (gum) trouble. This makes it sound like a losing battle to try to hold on to one's teeth; yet with a reasonable amount of care most of us could easily avoid this catastrophe and keep our teeth indefinitely.

Basically, the gingival tissue is like any other tissue. If you can keep it clean, you can keep it healthy. Unfortunately the mouth is the dirtiest part of the body and yet it very often gets far less attention in the way of cleansing than do the face or hands.

Gingival tissue will react to any local irritant. The most common ones are food debris and calculus. The latter, often called scale, is caused by a deposition of calcium and phosphorous salts from the saliva. By nature it is rough and porous and as a result is a perfect breeding ground for bacteria. The combination of physical and bacterial irritation places calculus high on the danger list in as far as the gingival tissues are concerned.

An early irritation causes a reddening of the gingival margin — where the gum attaches to the teeth. If the irritants are allowed to remain, a slow, continuous tissue reaction takes place. There will be areas of edema and the patient will complain of "bleeding gums." As in every infection, Mother Nature tries hard to repair the damage.

Very often this will gradually result in an acute gingivitis turning into a chronic gingivitis. By this time the edematous tissue has probably been



replaced by more fibrous tissue and perhaps the patient no longer notices quite so much bleeding. But as the infection has progressed it has brought about more tissue damage. The fibres that connect tissue to tooth begin to break down and we have the beginning of a "periodontal pocket."

If not corrected at this stage, the periodontal pocket will inevitably become deeper, destroying more and more of the attachment between tooth and tissue. Even if the teeth are properly cleaned and good home care is insti-

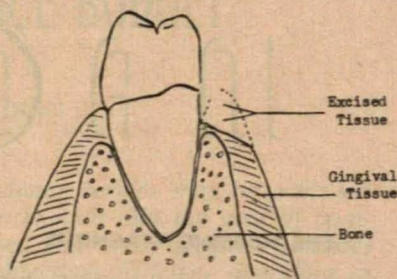
Dr. Stewart is on the Faculty of McGill University Department of Periodontology.

tuted it is impossible to clear up these pockets and to maintain them in a condition that will stop further breakdown. As a periodontal pocket progresses it breaks down the tissue-tooth attachment until it reaches bone. When enough bone has been lost, the tooth becomes loose.

Here then is the end result — a loose tooth. Yet it is obvious that in most cases, where local irritation is the cause, this whole process can be stopped. From the patient's point of view, a good home care routine is of utmost importance and biannual scalings by a dentist must go along with this.

If you are already in trouble, the type of treatment necessary to correct the condition will depend upon its severity. If caught in an early stage where there is little or no real tissue damage, a good scaling and proper home care if often enough. As the amount of tissue damage increases so does the severity of the treatment required. If the condition has progressed to the point where true periodontal pockets exist then these pockets must be eliminated. The tissue which is no longer attached to the tooth is excised after which it will heal, tightly attached to the tooth but at a different level. The patient now has a chance to keep this new tissue in a clean, healthy state. This surgical removal of tissue, gingivectomy, may involve any number of teeth

depending upon the extent of the condition.



Elimination of Pocket by Gingivectomy

A gingivectomy may be done with a reasonable chance of success unless the periodontal pockets have resulted in too much bone loss. Sometimes a loose tooth can be saved by cleaning out the trouble around it and then giving it additional support by splinting it to adjacent teeth. However, each mobile tooth is a problem in itself; generalities rarely apply to this condition.

This then is how you may lose your teeth. You can help to prevent loss by proper home care and by frequent dental check-ups. The whole process may be hastened or modified for you by your general physical condition. The more resistance you have, the more irritation these tissues can stand before trouble develops. This is a qualifying factor though and should not lead one into a feeling of false security. There is no substitute for proper home care.

In the Good Old Days

(*The Canadian Nurse* — DECEMBER 1923)

The private duty nurses in Alberta have been somewhat busier during the latter part of the summer. This has probably been due to the number of nurses who have left for other parts of Canada or the United States. There are no vacancies in hospital positions, and at present there is no prospect of any extension in either district or public health nursing. It is possible that there may be an increase in Red Cross Society activities.

Following the announcement by the American Child Health Association that an appropriation of \$10,000 would be set aside for furthering the education of nurses in child health work, 237 applications were received from the United States and Canada. Two awards were made to Canadian nurses — Miss Florence Emory, chairman of the Public Health Section, C.N.A.T.N., and Miss Muriel Martin, Toronto.

IN A CAPSULE

THE NURSING DIAGNOSIS

Virginia Bonney, director, Graduate Programs in Rehabilitation Nursing, New York University's School of Education, defines the nursing diagnosis as: "An evaluation, within current knowledge, of a patient's condition as a total human being including physical, physiological, and behavioral facets." The nursing diagnosis forms the basis for nursing therapy and nursing prognosis. It can be a valuable tool in evaluating patients' requirements for nursing care — in hospital and in the home. It is *not* a medical diagnosis made by a nurse.

Obviously, only a physician can establish a patient's medical readiness for discharge. A properly qualified professional nurse can decide what constitutes a specific patient's total nursing needs; also, whether the follow-up nursing care and guidance provided by the public health nursing agency on a visit basis will suffice for these total needs at any particular time. — Wensley, E. *Nursing Service Without Walls*, NLN publication, 1963.

AUTOMATION AND T.L.C.

The well-known hospital consultant, Gordon A. Friesen, spoke recently about automation at the Middle Atlantic Hospital Assembly in Atlantic City. He demonstrated how automation can be employed to assure the patient of "tender, loving care" by relieving the nurse of endless walking and messenger duties, which now occupy as much as 50 per cent of her time. Proper hospital design, combined with automation and employees trained in modern methods and techniques, can reduce hospital costs by 50 per cent and the number of employees by 25 per cent.

By putting everything on the assembly line *except* the patient, the patient remains the focal point to whom the staff can devote all of its skills, knowledge and understanding. — Callahan, B. *Hospital Progress*, 44:38, Aug. 1963.

COLLEAGUE RELATIONSHIPS

Much has been said and written about the attitudes adopted by senior nursing staff to their juniors, and how these attitudes should be revised if wastage, unhappiness and inefficiency are to be avoided. No one would quarrel with this — but it might behoove the junior members of the profession to consider the part *they* play in the business of colleague relationships.

A difficult, rude, or unsympathetic junior can be just as devastating to her senior, as seniors can be to their juniors. The junior may well say that if this is possible, there is a lack of strength and character at the top — but such a statement is no excuse for her own misbehavior.

What are seniors? Usually, they are women afflicted with the average amount of doubt about their ability and capability, the same problems and frustrations that beset us all, and possessed with a desire to be liked and to like. In other words, they are human beings.

Just as their juniors need courtesy, understanding and compassion from them, so do they need these things from their juniors. — Editorial. *Nursing Mirror and Midwives Journal*, 116:421, Aug. 16, 1963.

THE TELEVISION MENACE

Television programs may have serious mental health consequences on the viewers, especially children and adolescents. This statement was part of a draft resolution adopted at the 16th World Health Assembly of WHO earlier this year. Programs that rely on murder, theft, arsen, sexual offences and scenes of violence are said to encourage people, and especially young people, to undertake similar offences in actual life. It is recognized, the resolution stated, that films may exert a comparable negative influence, but television contributes a much greater menace by its power to penetrate into the privacy of the home, reaching a far greater number of children and adolescents. — *Clinical Pediatrics*, 2:8A, August, 1963.

NURSING SERVICE BUDGET

EDITH G. YOUNG /

Efficient operation of the department of nursing service may be achieved only when the philosophy of the institution is such that the goal of comprehensive nursing care may be attained and when adequate finances are provided for fulfilment of this objective. Efficient operation of this department also demands acceptance by the director of nursing of a business viewpoint with regard to hospital expenditure. This, in turn, implies effective administration and, therefore, efficiency of organization.

PART I

It has been stated that the difference between organization and disorganization might be compared to the difference between a heap of scrap iron and a locomotive. One remains forever a mass of unrelated scraps, while the other has been organized into a smooth-running mechanism. Indices of good departmental organization are found in the presence of written job descriptions and job classifications. Each member of staff must know his particular task, to whom he is responsible, and how his contribution meshes with that of other contributors to achieve the desired goal.

The easiest way to delineate responsibility is to set up a chart which depicts the areas of responsibility and establishes a basis for communications between the various groups comprising the whole. The *master hospital chart* shows the relationship of nursing service to the board of control, the medical staff, the administration and other hospital departments. The *nursing service organization chart*, on the other hand, indicates the relationships and formal channels of communication within this department.

There are different methods of preparing the chart. It makes little dif-

ference what method is selected as long as it is understood by the personnel using the chart. For example, whole lines may be used to demonstrate the line of authority and dotted lines may designate the staff who serve in an advisory or consulting capacity to the various categories of personnel. The chart, in itself, is of little value unless the interpretation and utilization of the principles behind it are understood.

The nursing department must be granted authority and resources appropriate to carrying out its assigned responsibilities and, in turn, must provide resources and delegate authority to personnel within its jurisdiction.

Planning Nursing Care

In addition to the organization chart there are other criteria for evaluation of nursing service which serve as a basis for planning good nursing care.

1. *A statement of the philosophy and objectives of a department to be used as a guide in planning, implementing and evaluating all the aspects and activities of nursing service.*

The philosophy includes and identifies the beliefs of the nursing staff concerning:

What nursing is;

the quality of nursing care to be provided;

the responsibility of administration for the continuing development of nursing personnel.

The objectives include the aims, goals and purposes.

Miss Young is assistant director and administrator of the Department of Nursing, Ottawa Civic Hospital, Ottawa. She presented her paper at the Conference on Budgeting held early this year.

2. Administrative Planning

a. Personnel:

Provision for recruitment and appointment of personnel with consideration of staff experience and interest as well as service stability in their assignment;

adequate personnel policies including health service and other conditions of work;

maintenance of an adequate competent staff;

effective utilization of personnel; policies and procedures governing appraisal of staff members' performance on the job;

participation of staff in the review and improvement of the service;

provision for development and growth through opportunities for further education;

b. Provision for inservice education for all staff including orientation;

c. Provision of adequate physical environment for patients and personnel in the nursing service;

d. Master staffing plan: This helps the director of nursing service visualize the equitable distribution of nursing personnel among the various nursing units. It serves as a guide in planning vacation coverage; as a timetable for replacement of personnel; as a support for budgetary requests; as an aid in forecasting future needs.

Daily and weekly time sheets and monthly summary reports of nursing service coverage are accompanying tools.

e. Regular evaluation of nursing care:

Hours of nursing care;

regular evaluating rounds to patients by director of nursing and supervisor; "opinionnaires" from patients and visitors;

analysis of data systematically collected re patients and personnel;

reports of performance of personnel giving nursing care;

evaluation conferences with nursing personnel;

evaluation conferences with medical personnel;

satisfaction and attitudes of personnel of the department.

f. Plans for comprehensive nursing care of the patient:

Provision for emotional, social, spiritual and physical needs including safety of the patient and for the medical or health plan of care;

assignment of personnel according to competency in relation to patient needs.

g. Conservation of energy and materials:

Provision of equipment and supplies adequate in quality and quantity to insure that the optimum effectiveness of the nurse's time and energy is promoted and the patient's safety ensured, for example, the provision of an adequate number of wheel chairs;

occasional observation and analysis of activities of personnel;

employment of mechanical devices, where possible.

h. Staff organization:

An opportunity for free communication and a share in planning and evaluation is provided through regular meetings of the director of nursing or her representative with day, evening and night assistants, supervisors, head nurses and total nursing staff. Records of these meetings include reports of decisions and recommendations. Members are informed of the administrative action taken on recommendations.

i. Communication:

Nurse with patients and families;

nurse with other workers and with medical staff in order to coordinate activities of the various groups involved in patient care;

Reporting:

Effective administration transmits and receives reports relevant to nursing service.

Annual reports with pertinent statistics and interpretation of service is transmitted to administration and to medical staff.

Exchange of information about and interpretation of service needs and changes among nursing administration staff, department heads and medical staff.

Policy, form, procedure and orientation manuals available to all staff.

j. Budget: Effective administration uses a budget for planning and control.

PART II

Preparation of Budget

A director of nursing service has, as one of her functions, the presentation of a budget that will allow for adequate personnel, supplies and equipment. The nursing service depart-

ment is the largest of all hospital departments with approximately 60-65% of all personnel. It, therefore, accounts for a major portion of the budget and is, consequently, under close scrutiny.

There are many factors that determine nursing service needs:

1. The type of patient, (medical, surgical, maternity, pediatric, communicable disease, tuberculosis, chronically ill), the length of stay, and the acuteness of the illness.

2. The size of the hospital and its bed occupancy. It takes more *total* personnel in the *large* hospital than it does in the *smaller* hospital to care for the same number of patients.

3. The physical layout of the hospital, the size and plan of the ward — open ward, small units, private ward.

4. Personnel policies:

- a. Salaries paid to various types of nursing personnel, including pay for overtime;

- b. The length of the work week and work period as well as flexibility of hours;

- c. The extent of vacation, statutory holidays and sick leave;

- d. Provision for inservice educational programs including instructional staff as well as relief staff;

- e. Provision for development of staff through university preparation, refresher courses, etc.

5. The grouping of patients, for example, segregation demands more standardization of equipment; specialized units such as neurological services, intensive care units will have differing needs.

6. Standards of nursing care: The kind and amount of care to be given as it affects the number of hours of bedside care, for example,

frequency of giving baths, changing beds, turning patients;

assisting the patient to be dependent when necessary, for example, patient with coronary attack;

assisting the patient to adjust to the degree of independence of which he is capable, for example, the patient with a fracture;

health teaching including methods of adjusting to normal living in the community.

7. The method of performing nursing procedures, simple or complex; the method of record-keeping and charting, for example, whether or not: all routine procedures such as baths and back rubs must be charted;

all medications must be recorded in the nurses' notes; a work sheet and checking system are in use. In the nursing analysis project of 1953, directed by the University of Pittsburgh School of Nursing and Method of Engineering Council, it was determined that if the methods of nursing procedures and routines in the medical centre were improved, the services of 38.9 people working 40 hours per week, 50 weeks per year could be saved.

8. The proportion of nursing care provided by professional nurses as compared to that provided by auxiliary personnel.

9. The availability of graduate and auxiliary workers, the ratio, and the utilization of both groups according to competencies and preparation.

10. The amount and quality of supervision available and provided; the efficiency of job descriptions and job classifications.

11. Method of patient assignment, for example, team nursing.

12. The amount and kinds of labor-saving equipment and devices; flash autoclaves; intercommunication systems; telautograph; carrier and pneumatic tube systems; electronic monitor for determining vital signs, etc.

13. The amount of centralized service provided; sterile supply; central oxygen service; postoperative recovery room; messenger and porter service; linen service including distribution of linen.

14. Whether or not non-nursing functions such as clerical, dietary, housekeeping, messenger and porter service are the responsibility of the nursing department.

15. The nursing service requirements of ancillary departments; clinics; admitting office; health service; emergency department, etc. These activities may be included in the responsibilities of the nursing department but should not be charged to nursing.

16. Reports required by administration, whether simple or complex.

17. Method of appointment of medical staff; size of staff; activities of medical staff; kind and frequency of treatments and orders.

18. Affiliation with a medical school: Inexperienced medical students need more equipment and supplies; cause more confusion and more interruption. Time spent for clinics should be charged to something other than nursing.

19. The presence, or not, of a school of nursing; the amount of nursing service hours available from students.

The changing patterns of nursing education have altered the place of the student nurse in the hospital, insofar as nursing service is concerned.

Preparation of the Total Budget

The total final budget is usually prepared under the direction of one executive head, such as the treasurer, comptroller or business manager with assistance from a hospital budget committee. The type of committee varies with the hospital. The coordinating committee composed of superintendent, assistant superintendent, treasurer and director of nursing might form the nucleus of the budget committee with representative department heads present when there is a discussion of items that relate to their individual departments.

It is essential that all available information about policies, changes in practice or procedures, and all proposed increases or curtailment of services, or any other factors that may affect the hospital bed capacity should be available.

A memorandum for departmental heads with predesigned forms for submission of the budget should be presented at least two months in advance of the date required for presentation of the budget. It should include:

Detailed instructions with examples for using the forms;

salary schedules for the specific department including information regarding increases, new positions, etc. Every hospital should have a minimum and maximum quotation of salaries; the statement should be gross whether or not perquisites are included;

a statement concerning anticipated price trends, listing the various types of commodities consumed plus the anticipated average per cent of increase or decrease, if possible;

a statement of the policies governing hospital expansion or renovations; repairs to be made by outside contracts; departmental requests for maintenance requirements; requests for capital expenditures;

a statement of the estimated volume of service to be rendered to patients during the budget period.

In addition to the above, the director of nursing should receive:

A statement of the previous year's costs

and statistics for the department of nursing as well as the figures for the year to date.

Statistics should include:

Average daily census per unit or per service for the past year, and the anticipated census for the budget year;

percentage of bed occupancy by months;

average length of patient stay for the past year;

total patient days and outpatient visits;

hours of nursing service per patient per day;

total paid hours of all personnel; daily average hours of private nurses in each unit or service;

the number of employees divided into their various classifications and the number of hours of effective volunteer work, if any;

information concerning expenses for education and supplies.

Budget

The department of nursing is usually concerned with the expense statement: salaries, equipment, supplies and capital expenditure. A budget committee should be formed within the nursing department. It might be composed of the nursing advisory committee; members of the nursing office administrative staff; supervisors of various departments; chairmen of head nurse and assistant head nurse committees; representatives of general staff.

The expenses in the nursing service budget as prepared by the director of nursing are generally only those under her control and are related, for the most part, to estimation of direct expenses.

Direct Expenses are those that are clearly identified with nursing service and that are charged directly to that department on the hospital's general books. They are usually specific items which can be found in payroll records, requisitions, and vouchers. They include such items as employees' salaries, education, supplies, and equipment used by the department.

Responsibilities of the Budget Committee

Each hospital must be considered as a separate entity in planning for its nursing service needs. In fact, each type of ward unit should be considered

separately. The over-all staffing pattern should be in the form of a master staffing manual. Each supervisor should work with the head nurses in her area to determine the minimal staff required for each unit. The following factors should be considered:

1. Assurance of standards according to the philosophy and objectives of the hospital and of the department of nursing;
2. past experience of the unit;
3. anticipated needs for the ensuing year.

It is helpful to consider the factors that affect nursing requirements in each unit. Estimation of staff should be based on previous experience and anticipated needs for the ensuing year. Percentage occupancy should also be considered. It is less complicated to estimate first the staff required on a weekly basis with provision for relief on days off duty. Relief required may be estimated in terms of professional and non-professional staff days required for the unit per week.

The estimation of staff for the unit per year can be determined from the weekly total. It should include provision of relief for annual leave, statutory holidays and the average amount of illness per nurse per year. The number of hours of nursing care and nursing service per patient per day should be estimated from this total.

The estimation of staff for each unit by this technique provides a simple visual method of interpreting nursing care and nursing service needs to the superintendent, the budget committee and the finance committee of the hospital. The total staff for the department estimated by this method can be checked against the total patient days in the nursing service department multiplied by the nursing service hours per patient allowed by the hospital administration. For outpatient and specialized nursing units, the same plan is followed.

The next step is to ascertain what changes are contemplated, such as opening new facilities for patients, changes in provision of inservice educational programs, changes in other departments that affect the nursing service required.

In the preliminary budget, nursing service personnel requirements should be stated in terms of professional grad-

uate nursing personnel and non-professional auxiliary personnel. In hospitals with a school of nursing, the philosophy of the school of nursing should determine the contribution of the student to nursing service.

There are few standards available to assist in the estimation of staff requirements for nursing care and nursing service. The Department of Health, province of Ontario, published *An Analysis of Hospital Experience for Student Nurses in Schools for Nursing in Ontario* in 1956. The figures presented are not standards but they reveal the situation that existed in Ontario as indicated by information taken from questionnaires submitted to hospitals of varying capacities.

The Hospital Nursing Service Manual, published by the American Hospital Association and the NLNE in 1950, indicates the results of the study of nursing service in one children's and 21 general hospitals. The number of bedside hours that should provide good nursing care are listed.

One must be careful not to rely on any one set of figures. It is interesting to note that the recent report of the Nursing Care Survey of Alberta revealed the fact that

The quality of nursing care is not necessarily dependent on the number of hours of care. Deficiencies in hospital plant and inadequately trained nursing administrators were the most frequent cause of inferior quality of patient care in the hospitals studied.

Requirements for administrative staff, supervisors and head nurses must be determined on the basis of experience.

The hours of nursing service per patient per day for the past budget year must be reviewed in order to determine:

Whether the amount of nursing care provided was comparable to what is considered minimal for safe nursing service. Figures for comparison may be available from "the daily record of nursing service hours per patient per day" which is prepared daily by the ward clerk and submitted each month to the nursing office.

Whether the quality of nursing care met the preestimated standards and whether it could be maintained by using more auxiliary and non-professional personnel and fewer

professional personnel by a prearrangement of duties and responsibilities, for example, an additional number of secretarial staff in the evenings.

Whether any dietary, housekeeping or messenger services carried out by nursing personnel could be more economically performed by their respective departments, for example, by the employment of additional bed makers by the housekeeping department, or of dietary aides to carry trays and nourishment to and from patients by the dietary department. Facts and figures must form a part of this study.

Whether the organization of the unit could be improved by a revised assignment of duties or, for instance, by the placement of equipment in a standard place on all wards;

Whether patterns of nursing care should be rescheduled;

Whether improved methods of segregation of patients should be recommended so that a ward may be completely equipped for expected needs.

Listing Equipment

A questionnaire to establish the needs for each unit should be completed by each member of teaching, administrative, supervisory, and head nurse staff for her specific department. For example:

The budget for 1964 is to be estimated before the end of this year. Kindly indicate on this form the requirements of your department.

a. Structural changes desired.

b. Equipment needed, such as desks, cabinets, carts, chart desks, or equipment of similar type.

c. Extensive replacements of equipment.

d. Miscellaneous items.

Request the chiefs of staff of various services to make specific recommendations relating to equipment and supplies, and record these on the same form. Kindly ask the chief of staff to sign the budget items requested by him.

Preliminary Budget Draft

Having reviewed, classified and summarized the information received from nurses in charge of units, and having conferred with them, the next step is to review the budget appropriation and the actual expenditures for the current year, from information furnished by the accounting department, in conjunc-

tion with statistical data as to the numbers and distribution of patients, nursing hours per patient by services, operations and other pertinent information.

Prepare the program that the new budget is to cover in terms of nursing hours to be given to patients; the distribution of the hours among the various groups of personnel; the ratio of supervisors and head nurses to patients; the provision of administration of the nursing department.

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Censure is the tax a man pays to the public for being eminent. — JONATHAN SWIFT

A Head Nurse is the Patient

IRENE H. BROWN

A head nurse's views undergo changes during her stay as a patient in a hospital.

What a difference between being the charge nurse on a surgical ward and being a patient! I have been both, and I feel a great "urge" to describe my feelings as a patient. Head nurses generally experience similar reactions to certain circumstances. Do patients share common feelings in relation to a hospital and its nursing staff?

From the time I saw my X-ray plates in a gall bladder series, with those large stones so plainly saying "cholelithiasis," I was a kindred spirit with the patients rather than the nurses. First, I discussed the "pro's and con's" with my family doctor and then other doctors — of course using "my case" impersonally. Then I finally made up my mind that I had to have surgery and my doctor and I discussed my condition with the surgeon who would do the job. He agreed that a cholecystectomy should be done as soon as it could be booked in the operating room. After discussing the problem of my relief for time off, etc., with the director of nurses and the administrator, I booked my own surgery for October 26, 7:45 a.m. What an odd feeling to see the order in the O.R. book! Yet how many dozens of other people I had booked with a feeling of "Oh, yes another 'choley'; not too many complications; usually do very well; suction tube, enema, etc." But now, what a glaring meaning all this had for me!

The big day came all too soon. On admission I remarked, "Now I know how those big brown-eyed steers feel when being led to a slaughter house."

Mrs. Brown was the evening supervisor on the staff of Matsqui-Sumas-Abbotsford General Hospital, Abbotsford, B.C. when she wrote this account of the nurse as a patient.

"Sign here please." — "But this is the wrong side. I've always signed on the other side." I had signed as a witness so many times.

Even the hospital looked different although I had worked there for over four years. Everyone was so friendly and welcomed me so warmly. Even the matron came out of her office and very graciously escorted me to the private room that had been prepared for me. How many of our patients get this kind of a welcome? Nevertheless I still felt strange and alone; the bed looked so cold and white. As I put away my personal things in drawers, hung up my clothes in the closet, and put on my pyjamas I began to feel somewhat better. I climbed into bed and tried to relax. The nurse came in and took my blood pressure — 170/90! I was one patient who should have been well prepared, well oriented. I was familiar with my surroundings and all the routines. How much more alarming hospital admission must be to the average person who, perhaps, has never been inside a hospital before?

I was tense and frightened when the surgeon came to give me my pre-operative check-up, and when the anesthesiologist arrived to carry out his examination. I knew both of these doctors well and had the greatest respect for them. How does one feel who does not know the doctors at all? Some patients do not understand why all of these preparations are necessary. How confusing it must be for them!

The morning of surgery went off very nicely. Swallowing the Levin tube was as horrible as I had expected, but I at least knew that it was essential. Arriving in the O.R. I was relieved when I saw my surgeon and family doctor scrubbing. They spoke to me

in friendly, calm voices. I wonder if they realized how terribly important it is to the patient to have this one last glimpse of her doctors before the mask is clamped down over her nose and the anesthetic started?

My first sensation on awaking was "Oh, they can't do my surgery; I'm having a terrible gall bladder attack." But the nurse assured me that my operation was over and that this was why I was having pain. During my first three days as a postoperative patient it seemed that I was reduced to the status of a three-year-old. I am sure that I whined more than I spoke. I was having considerable pain and I did not have any desire to accept it. Since I was under sedation most of this time, everything seemed a little blurred; I wanted terribly to lean on anyone near me. Now I can understand why the strongest person wants to hold your hand and cling to you. Personal contact really gives you strength. This is the time when you are very much aware of whether or not a nurse is sympathetic and understanding or just plain professional.

I was keenly alert to the nurse's tone of voice; what she said; how she reacted to my requests. Actually what I needed at this time was the assurance that she was really interested in me as a person, not just interested in my symptoms.

One incident that happened on the second day following surgery stands out vividly. I had developed pneumonia in a lobe of my left lung. Coughing was extremely painful but the doctor insisted that I must remove the phlegm. After hours of trying to do this my incision was very sore. The head nurse came into my room and asked "How are you feeling?" I answered plaintively that "My incision is certainly painful." She mimicked my whiney tone of voice and my words, teasing me, I presume. If I had been able to reach my vase of flowers, I would have thrown it at her! On the other hand, if one of my patients had behaved in this manner, I would have considered her "neurotic."

The doctor's visits were highlights in each day. The surgeon came in three times a day for the first three days, the family doctor every day and, being a

nurse, all the other doctors would pop in to say "hello" occasionally. To my surprise I found myself wishing that, occasionally, the charge nurse would be too busy to accompany the doctors. There were questions I wished to ask that I would not discuss when the head nurse was present or, in fact, if any nurse was present. I wonder how many patients feel this way? As a head nurse I had always felt that it was good ward management to go with any doctor making rounds. It seemed desirable not only for the doctor's sake but also to point out little things that the patient seemed hesitant to mention. I discussed this later with a doctor and learned that he, too, had sensed this need in patients but he had understood that it was routine hospital policy to have a nurse with him. It was difficult to know where to draw the line.

Another thing that bothered me as a patient was laughter between a doctor and a nurse if I did not know what they were laughing at. One day the doctor and nurse changed my dressing. I felt that I was rather grossly exposed during the procedure. As they left the room something was said and they both laughed rather loudly. I had the uncomfortable feeling that they were laughing at me. Later, of course, I realized that this was a ridiculous idea, but when one is the victim of such circumstances it is amazing how important little things become. How often I had laughed in exactly the same way when making rounds with a doctor.

I was amazed to discover how much time the ward aide spends in the ward. How very important it is for them to have good ethics! How much thought and training does the average hospital provide for these girls?

I was also surprised to find how much the visits of the various supervisors meant to me. I found myself looking forward to seeing them. They seemed to have a little more time to spend with me and to be more relaxed. As a result I felt more relaxed and cheered. The ward nurse always appeared rather rushed and I hesitated to interrupt her with my little troubles or comments, but I looked forward to seeing the head nurse and to having a little chat with her. Previously as a

head nurse I enjoyed making rounds to see the patients but I was under the impression that this was beneficial to me rather than the patients. How differently I feel now when I make rounds!

My original views about visitors have changed. What a comfort it was to have my husband and children come in to see me. I wanted my children in for just a few minutes each time but I would have liked to have had my husband sit quietly by my side for hours on end. Two of my sons were too young to come in since they were under sixteen; I worried about them. I mentioned this to the matron and she gave permission for them to visit. What a relief to see them, and it made me feel so much better!

Meals! They all looked huge to me: coffee and tea tasted the same. Yet everyone was wonderful to me. The dietitian and the cook visited me; they did all that was possible to tempt my appetite. I think I hated worst to complain about my meals because everyone tried so hard to please me. However, most patients are not interested in food for some time after surgery.

Incidentally, I was very interested to find out how completely satisfying intravenous therapy is. I was neither thirsty nor hungry. I received intravenous solutions for three days and the only discomfort was the inconvenience of getting up to the bathroom while attached to the apparatus. In fact, it

would have been easier to continue with this than to start to eat again.

Even before surgery I worried about not being able to void and, of course, I could not void for some time after operation. The nurses told me that I was hardly conscious before I asked for a bed pan, so I certainly must have had this on my mind. How extremely uncomfortable it is to have a full bladder and void about one-half ounce. One nurse said "You didn't really have to void very badly, did you?" *That* remark I will never make to a patient from now on. You feel so terribly inadequate; it is so frustrating to have the desire to void so badly, and yet not to be able to do so. Never again will I pass a postoperative patient without checking her output. These aspects of care are so vital to a patient's comfort and they are important to the head nurse as well but when one realizes personally *how* important they are, it puts a different light on the problem. Certainly you "feel" for the patient who is having difficulties.

I have found it interesting to set down my personal reactions and I wonder how many other head nurses would agree with my views or have had similar experiences. I have been a nurse for years and, although I think I have a sympathetic and understanding nature, I realize how helpful this experience has been for me. I hope that nurses who read this account may benefit in some small way.

Coming!

IN

JANUARY 1964

MacLennan — A Sense of Values

Lewis — Lore and Lure of Newfoundland

Ramsay — Observations of a Ward Patient

Hamilton — Continuing Education

Fee — Otosclerosis

Gauthier — Promotion and the Nurse

plus additional material

Diary of a Nurse

ANNIE BROOKE HIBBARD

My name was Annie Emily Brooke, known to my classmates as "Brookie," when I entered The Montreal General Hospital, then on Dorchester Street on March 27, 1898 to take the three years' training as a nurse.

The new Nurses' Home was not completed when I started so for the first month I had to share a room on the top floor of the hospital with a night nurse. She slept in the bed during the day; I occupied it at night. This arrangement lasted only a few weeks. When we moved into our new Home each nurse had her own nicely furnished room.

The day began at 6:15 each morning. After a quick breakfast we reported in the ward by seven o'clock. We had no training at all before we started work in the wards. We were on duty from seven in the morning until seven at night, sometimes with one hour off during the day, when convenient. I was sent to the Children's Ward, Ward O, that first morning, and was there for several weeks. One day I will always remember! I was washing out diapers in a sink when called to the ward. I left the tap running so water flooded the bathroom floor and I had to use a dustpan to take it up. I thought I would certainly be dismissed, but not so.

We received no pay for the first six months. The first year we received \$6.00 a month; the second year \$7.00 and the third year \$8.00. Out of this we had to pay for our books, caps, and any broken thermometers.

My next move was to Ward H, the Men's Medical, where there were about eight beds, nearly all with typhoid patients. Poor men! How they hated to be got ready for an "ice bath"! This meant that when their temperatures were about 103° they had to be lowered into a bath tub full of cold water with a "cage" at the foot of the bath containing chunks of ice to lower the temperature still further. Two nurses

sponged the patient for fifteen minutes without stopping. He was then put back to bed until it was time for the next bath — about every four hours. This was very harsh treatment, but it usually worked and the patient got well.

At the end of six weeks I got my cap. I was then in Ward M, the Men's Surgical. After that I was off with jaundice for a month.

Ward K, the Women's Surgical, was my next stop. After being on day duty as a junior I was put on night duty, from 7:00 p.m. until 7:00 a.m., all by myself, with entire charge of 27 beds and two private rooms. I was there for nearly six months, with only one night off, and that was from noon to midnight. When on night duty we had no time off at all during the night. We had to take a lunch basket for our midnight meal — if we were not too busy to eat it. This was usually a beef stew, with tomatoes, and how tired we got of it! One old patient was very fond of tea so I always gave her a cup when I was having my midnight meal. One night she whispered to me, "Nurse, I have a present for you in my table drawer. Get it when the other patients are asleep." I did, to please her. It turned out to be a very sticky bun in a paper bag, wrapped up in a dirty black petticoat! The bun I threw out the ward kitchen window, and may have surprised a passerby if it landed on his head.

One night a patient on my ward died. I had never been shown, or told, what to do if this should happen, and I did not know how to close the eyes. The nurse sent to help me had no idea either. Finally, I took a piece of Mead's Plaster, folded the sticky sides out, and placed it on the eye-

ball. What I should have done was to place a tiny piece of tissue paper under the lid. Next morning, the story was all over the hospital. Several of the doctors came to see me to ask for a bit of Mead's Plaster — "just enough to put in my eye." After I graduated I went to tea with an old graduate nurse. She told me this story, but said that she did not believe it. When I said that I had been that nurse, she nearly fell off her chair. At Christmas tree time, when once a year we were allowed to mingle with the doctors (in uniform only, never in pretty dresses) I was called up to the tree to receive two dolls dressed in white with Mead's Plaster over their heads and a label that read: "When in doubt, use Mead's! Brooke and Magee, Undertakers."

Another nurse once had to give a patient a stomach tube to swallow. She thought she would try it herself first, and did so behind a screen, only to be surprised in the act by one of the doctors. Naturally, her present from the Christmas tree that year was a stomach tube, with appropriate verses.

My next term of duty was in the Women's Medical ward. Also, for over a year, I spent two afternoons a week working in the G Operating Room from four until nine or ten o'clock at night. For this we never were given any extra time off, and had to be up at 6:15 as usual next morning. I was most fortunate to be on duty in that operating theatre when the first Caesarean operation ever done in Montreal was performed. This was in 1899. How proud the doctor was! The theatre was crowded with students, and when the baby appeared they called out, "Call him Caesar," and took up a collection for him. Strange to say, another such operation was performed in the Royal Victoria Hospital the next week, but we of the General were very proud to have been the first.

For some time I looked after five private wards, until, to my joy, I was sent in charge of the "Outdoor Section" of the Hospital. There I worked with visiting surgeons and doctors who came every morning to interview patients and to do small operations and dressings. It was a busy time for I was all alone there and had to make all the dressings, bandages, etc.

When in the outdoor I used to do special dressings on the hand of an old Italian organ grinder (no monkey). He said he would come and play to me. One afternoon, when a doctor was lecturing us stu-

dents, he arrived in the street below playing "I'll Leave My Happy Home for You" — much to the annoyance of the doctor. I tried to wave him away, but the more I waved the more he played, smiling up at me. Finally, I got him to move on and peace was restored.

I had charge of several different wards during my course. In those days there were no graduate nurses in charge of wards as there are now. We worked up from junior to head nurse. This, I think, was a good idea as it gave us more responsibility. For my final two months I was assistant night supervisor to Miss Webster who was night supervisor for about thirty years. When she was off duty twice a week I was left in charge of everything. I had to make rounds of the entire Hospital three or four times during the night. Should there be an emergency operation I had to arrange everything and hurriedly call the nurses who were on duty to get up and go to the operating room. I had to be present at any deaths and I had to attend patients in the outdoor during emergency calls. It was a busy life, but I enjoyed those two months very much.

The day after I graduated I came down with a very bad attack of scarlet fever and was in bed for five weeks on the top floor of the Hospital. When we graduated our marks were put up on the notice board in the hall. There were no dinners, dances, flowers and pretty dresses for us. We had to buy our own medals, which cost us five dollars. I think the number on my medal was 176. We were given our first two private cases in the Hospital to earn a little money (which we badly needed).

We received \$2.00 a day as pay on private cases, sometimes being on duty for the whole 24 hours. If we went to nurse in the United States we got \$3.00 a day. I might add here that my first case was at a place near Saranac Lake. It was a woman who was exceedingly ill with typhoid fever. She was a very trying woman who had had five nurses in ten days and fought with them all. Now she thought she would try a Canadian. She greeted me with the remark: "Well, at least you look *clean*." I replied, "Thank you." I was with her for 5 weeks. There was no doctor for six miles, and there was no telephone. The doctor had to bring all the drugs and other things with him. When I finally left I had \$100.00 in the leg of my stocking. We wore long skirts in those days. I felt very rich.

I remember there were only two restaurants on St. Catherine street in those days. One was the BonTon. We used to go there for dinner as a great and rare treat. A three-course dinner cost twenty-five cents, but we seldom had that much to spare.

I went back to the dear old General and had several cases there. The following year I was married to Walter Robert Hibbard, senior mathematics master at Trinity College

School, Port Hope, Ontario. When I told Miss Livingston, Superintendent of Nurses, that I was going to be married, she said, "I do not train my nurses to get married. Bring him to see me." But after meeting him she quite approved. In 1908 he was appointed Headmaster of Rothesay Collegiate School and was there for thirty years. After retirement we built a little house in Rothesay, N.B. in which I am still living.

In Memoriam

M. T. Eliette C. Audy (Notre Dame Hospital, Montreal '56) died in La Tuque, Quebec, earlier this year as the result of an accident.

* * *

Nellie Agnes Florence (Lane) Blair (Wellesley Hospital, Toronto '43) died recently. She had been employed in institutional nursing.

* * *

The alumnae association of the Royal Victoria Hospital, Montreal, pays tribute to the memory of: Mabel Burdon '25; Mima Russell '96, a member of the first graduating class who was in her 97th year; Gladys E. (Dougall) Young '28.

* * *

The alumnae association of The Montreal General Hospital pays tribute to the memory of: Beatrice (Vooght) Cook '99; Anna Mae Hutt '23; Hattie Patterson Tanner '25 and Frances Walker '10.

* * *

Mary Catherine (Corrigan) Coolican (Grey Nuns' Hospital, Regina '37) died this summer as the result of a boating accident.

* * *

The alumnae association of the Ottawa Civic Hospital has reported the death of the following graduates: Eleanor (Ross) Gardner '27 and Amy (Hutchison) Keon '28.

* * *

Norah Kathleen Knox (St. Joseph's Hospital, Victoria '19) died in Victoria on September 2, 1963. She retired from nursing in 1952 after 17 years on the supervisory staff of Vancouver General Hospital.

Mary Frances Lytle (Highland View Hospital, Amherst, N.S. '43) died in Halifax on September 1, 1963 after a brief illness. Formerly nursing arts instructor on the staff of the Children's Hospital, Halifax, she was director of nursing education, Victoria General Hospital, Halifax at the time of her death—the position she had filled since 1955.

* * *

Opal (Trammell) Miller (St. Boniface Hospital, Man. '39) died in Denver, Colorado on September 11, 1963. During World War II she served with the American Navy and later was charge nurse of a pediatric unit in a Denver hospital.

* * *

Catherine Pearson (Erie County Hospital, Buffalo, N.Y. '19) died in Toronto on September 8, 1963.

* * *

Alice (Moreton) Peirce (Winnipeg General Hospital '06) died in Brandon, Man. on August 8, 1963 after a long illness. A past president of Brandon Graduate Nurses' Association, Mrs. Peirce took a very active part in the work of local blood donor clinics and, during World War II, in various activities contributing to the war effort.

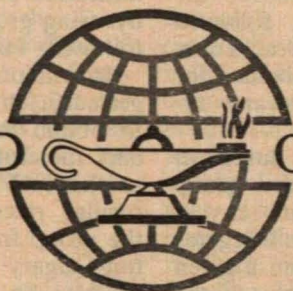
* * *

Katherine (Tena) (Buhler) Penner (St. Boniface General Hospital, Man. '60) died on July 4, 1963. She was on the staff of Victoria General Hospital, Winnipeg.

* * *

Frances Mary Phillips (Toronto Western Hospital '18) died in Toronto on August 1, 1963. She had engaged in private nursing.

THE WORLD OF NURSING



PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION,
74 STANLEY AVENUE, OTTAWA

Convention Newsfront

September 19 brought together the members of the 32nd Biennial Program Committee to discuss planning details for the convention in St. John's and to explore new ideas to make it an unforgettable reunion. Discussions during the day-long meeting centred on the format for the business sessions, guest speakers, special events for student nurses and activities for alumnae associations.

Although the roster of speakers is not yet finalized (top speakers in and out of nursing have been invited but are checking their commitments for June) we can tell you that ICN president, Mlle ALICE CLAMAGERAN of France will be the keynote speaker. So that she may deliver her speech in her native tongue, simultaneous translation will be provided for all registrants. This service will also be made available throughout the week to facilitate other speakers in using either language. DR. KASPAR D. NAEGELE, associate professor of sociology at the University of British Columbia, will be another of the guest speakers.

Delegates will be able to register from 10:00 a.m. to 5:00 p.m. on Sunday, June 14. Arrangements have now been completed for church services that evening at St. John the Baptist Cathedral (Anglican), Gower Street United Church and the Basilica. A daily mass

will also be held at the Basilica throughout the week.

Registration will resume June 15 at 8:00 a.m. and at 9:30 the official opening of the convention will take place with the Invocation given by the Lord Bishop of Newfoundland.

Throughout the week the student nurses of St. John's will act as couriers. You will be able to recognize them in their white pleated skirts and red, white or blue blazers and matching headbands.

The theme throughout the convention will encompass nursing as a whole so that the student, the hospital nurse, the public health nurse, the instructor and the administrator will not only be able to contribute more to the meeting, but will be able to take more away from it. You will be hearing about the Royal Commission on Health Services and its implications for nursing; patterns of nursing care and implementation; and you will take part in discussion groups on all fields of nursing.

Though much work has yet to be done on the business side of the convention — and these details will be passed on to you as they are finalized — the social side should prove to be a delightful experience. Two mornings have been set aside for special breakfasts should the alumnae associations wish to hold them. The nurses of New-

foundland have planned a boating trip in the Conception Bay area for the free Wednesday afternoon, followed by dinner at the Velvet Horn. Tours and a barbecue supper are planned for student nurses. Other tours and receptions are in the planning.

Now, how to get there. Based on regulations presently in effect, group rates can be applied from any city in Canada providing 10 or more delegates travel on the same plane from a given city. Under present regulations, if the group numbers 16 or more, all from the same point, *the 16th ticket will be free*. Domestic rates within Canada are of course subject to change without

notice, but in order to give you some indication of the savings to be effected by using group rates, we give you the following information:

It will probably not be possible to get sufficient members from all points to obtain the benefit of group rates, and therefore, it might be necessary to have Victoria nurses travel on regular rates to Vancouver and join the group from that city. The Edmonton-Calgary nurses may have to concentrate on either one of these cities, and, likewise, those from Saskatoon and Regina may have to use regular rates to Winnipeg and join a group there.

To St. John's	Regular	Regular	Group	Group
From:	One Way	Round Trip	One Way	Round Trip
Vancouver and Victoria	\$180	\$360	\$164	\$328
Edmonton and Calgary	160	320	144	288
Saskatoon	153	306	137	274
Winnipeg	123	246	112	224
Toronto	83	166	74	148
Ottawa	69	138	61	122
Montreal	60	120	54	108
Saint John	49	98	42	84
Halifax	37	74	32	64

Red Cross International Nursing Study Centre

DR. HELEN K. MUSSALLEM, executive director of the CNA, was one of 90 nurses from 29 countries represented at the Red Cross International Nursing Study Centre held in Lausanne in August, where the role of the Red Cross nurse in today's world was discussed in a five-day meeting. Lectures and discussions centred round the basic foundations of the Red Cross and their application to nursing activities. The Geneva Conventions were studied and the participants discussed and sought the best way through which knowledge of these Conventions could be disseminated within national societies through schools of nursing, national nurses' associations and the medical

services of the armed forces. Other topics discussed were: Nurses in National Defence; Recruitment and Enrolment; Preparation and Education; Administration of Nursing Services; and Relationship of the Red Cross with national and international organizations interested in nursing.

International Council of Nurses

PRESIDENT E. A. ELECTA MACLENNAN and executive director Dr. Helen K. Mussallem attended the ICN Board of Directors' meeting in Geneva in August where it was announced that the 1965 Quadrennial Congress will be held in Frankfurt, Germany. The meeting also disclosed that the Board

of Directors unanimously agreed to recommend to the Grand Council the Resolution put forward by the Trinidad and Tobago Registered Nurses' Association to award DAISY C. BRIDGES, former General Secretary of the ICN, Honorary Recognition for the invaluable services rendered to the ICN during the years she filled the office of general secretary.

International Visitors

MISS PRAMDA ARORA and MRS. SOSAMMA GEORGE EAPEN, both of India, spent a day in National Office

on their way to the University of Toronto where they will take postgraduate work. Miss Arora, a graduate of the Delhi College of Nursing, already holds three degrees — bachelor of science (honors) in nursing, public health supervision and a master's in psychology. She has been working in a school health pilot project for the past seven years. Mrs. Eapen, head nurse at the Lady Willingdon Hospital in Delhi is a graduate of the Lady Harding Hospital and will return to her old position. Both came to Canada under the Colombo Plan.

Canadian Nurses' Foundation

The following persons constitute the 1963-64 Board of Directors:

President, Miss Mary Richmond, Associate Professor, School for Graduate Nurses, McGill University, Montreal.

Vice-President, Miss Ella M. Howard, Director of Nursing, New Mount Sinai Hospital, Toronto.

Directors: Miss Alice Girard, Immediate Past President, Dean, Faculty of Nursing, University of Montreal, Montreal.

Miss E. A. Electa MacLennan, Director, School of Nursing, Dalhousie University, Halifax.

Miss Lillian E. Pettigrew, Executive Secretary and Registrar, Manitoba Association of Registered Nurses, Winnipeg.

Dr. Helen K. Mussallem, Executive Director, Canadian Nurses' Association, Ottawa.

Rev. Sister Mary Irene, Director of Nursing, Charlottetown Hospital, Charlottetown.

Miss Helen Carpenter, Director, School of Nursing, University of Toronto, Toronto.

Mrs. Eva McCutcheon, Toronto.

Executive Secretary-Treasurer, Mrs. Lois Graham-Cumming, Ottawa.

Notice of Meeting

The President, Miss E. A. Electa MacLennan, wishes to announce that the General Meeting of the Canadian Nurses' Association will be held June 14-19, 1964, at the Memorial University of Newfoundland, St. John's, Newfoundland.

Helen K. Mussallem,
Executive Director.

AORN Congress

The new Memorial Auditorium in Dallas, Texas, will be the site of the 1964 Congress of the Association of Operating Room Nurses, March 1-5.

The four-day program reflecting the theme "New Dimension of Operating Room Nursing Practice" will have sessions of interest to all levels of operating room nurses. Some 200 technical exhibits will display new products, and approximately 25 scientific exhibits will portray the latest surgical techniques and procedures.

Congress Headquarters will be at the Adolphus Hotel, Dallas. Further information may be obtained from AORN Headquarters, 151 East 50th Street, New York, New York 10022.

Some people read to get away from life; others read to get into life, to experience it more abundantly.

There are virtues in both purposes. For escape from the vexation of events, we may immerse ourselves in books of our choice; we may read for information, to stimulate thought, to help our personal development, or because we enjoy reading.

—The Royal Bank of Canada

Monthly Letter, vol. 44, Aug. 1963

TO EUROPE ANYONE?

JUNE FERGUSON

Ask your next door neighbor where she'd like to spend her vacation and dollars to doughnuts she'll tell you Europe. She'll also add, "but I can't afford to go — I'll be spending mine in Canada!"

Now, a vacation in Canada can be pretty exciting and I'm the first to

support "See Canada First." But if you haven't yet been to Europe (and even if you have), read on and see what Thos. Cook & Son are offering the nurses of Canada following the convention in St. John's that will make that next door neighbor wish nursing had been her chosen field.

Day by Day Itinerary

SAT. JUNE 20

Leave St. John's by afternoon plane for Gander, departing same evening for Prestwick.

Arrive Prestwick. Continue by motor coach via the Trossachs for Edinburgh.

EDINBURGH

MON. JUNE 22 to

Arrangements will be made by the CNA for two days' professional

WED. JUNE 24

observation visits. Ample time will be allowed for independent sightseeing visits in and around Edinburgh.

THUR. JUNE 25

Leave Edinburgh by morning plane for London.

LONDON

FRI. JUNE 26 to

Three days will be planned for professional observation visits in-

TUES. JUNE 30

cluding the International Council of Nurses Headquarters, the Royal College of Nursing and National Council of Nurses of the United Kingdom, hospitals and health agencies, according to the wishes of the nurses.

Thos. Cook & Son will provide a motor coach for a drive to Oxford for professional visiting and to the University Colleges and Blenheim Palace. Arrangements for professional visits will be made by CNA. Again, there will be time available for independent sightseeing arrangements.

WED. JULY 1

Leave London by air for Amsterdam.

AMSTERDAM

THUR. JULY 2

Morning drive around old and modern Amsterdam including the Royal Palace, Rembrandt's House, Portuguese Synagogue, Nieuwe Kerk, Oude Kerk and Stock Exchange, and a visit to the Rijksmuseum and one of the diamond-cutting workshops.

Afternoon drive to the picturesque fishermen's village of Volendam and a boat-trip to the isolated Isle of Marken where old Dutch costumes and customs are proudly maintained.

FRI. JULY 3

Leave Amsterdam by train for Brussels.

BRUSSELS

- SAT. JULY 4** Short tour of the city visiting the Bourse, Town Hall, Fountain Boy, Palais de Justice, Royal Museum, Parliament and Sainte-Gudule Church.
- SUN. JULY 5** Leave Brussels by morning train for Koblenz, and continue by Rhine steamer to Wiesbaden.
- MON. JULY 6** Leave Wiesbaden by morning train for Munich.

MUNICH

- TUES. JULY 7** Half day city sightseeing.
- WED. JULY 8** Leave Munich by rail for Vienna.

VIENNA

- THUR. JULY 9 to SAT. JULY 11** One full day sightseeing.
- SUN. JULY 12** By day train to Venice.

VENICE

- MON. JULY 13** Morning sightseeing stroll visiting the Church of St. Mark, the Doge's Palace, the Dungeons and the Bridge of Sighs. Thence by motor boat across the City and Lagoon, passing the Island of St. Michele (Cemetery of Venice) to Murano, where one of the principal glass-blowing factories will be visited.
- TUES. JULY 14** Leave Venice by rail for Florence.

FLORENCE

- WED. JULY 15** Morning drive including the Medici Chapels, Cathedral, Giotto's Campanile, Baptistery, thence via the Piazzale Michelangelo to the Pitti Palace to visit the famous Gallery.
- Afternoon motor tour of the city including the Palazzo Vecchio, Loggia dei Lanzi, Uffizi Gallery, Santa Croce Church where Michelangelo, Galileo and Machiavelli are buried, the Protestant Cemetery where Elizabeth Barrett Browning is buried, thence to the beautiful village of Fiesole overlooking Florence and the Valley of the Arno.
- THUR. JULY 16** Leave Florence by motor coach for Rome.

ROME

- FRI. JULY 17 to SUN. JULY 19** Morning drive visiting the Vatican with its Museum, the Raphael Rooms, the Sistine Chapel and the Villa Borghese.
- Afternoon drive visiting Piazza Venezia, Square of the Capitol, Roman Forum, Colosseum, Church of St. Peter in Chains, Basilica of St. Paul Outside-the-Walls and Janiculum for a fine view of the city.
- MON. JULY 20** Leave Rome by rail for Naples.
- TUES. JULY 21 to** Two-day trip to Sorrento and Capri.
- WED. JULY 22** By night train (sleeper) from Naples to Genoa.
- THUR. JULY 23** By motor coach from Genoa to Nice.

NICE

- FRI. JULY 24** Afternoon excursion via Gorges du Loup to Grasse. Visit perfume factory.
- SAT. JULY 25 and SUN. JULY 26** By motor coach via Grenoble to Geneva.

GENEVA

- MON. JULY 27 and** Tour of the city and planned professional visits to the World Health
TUES. JULY 28 Organization, League of Red Cross Societies and other points of interest, through the courtesy of Miss LYLE CREELMAN, Chief, Nursing Section, World Health Organization.
- TUES. JULY 28** Leave Geneva by night train (sleeper) for Paris.

PARIS

- WED. JULY 29 to** Morning tour of the city by motor visiting the Louvre Museum,
FRI. JULY 31 through the Tuileries Gardens and along the Champs Elysees to the Arc de Triomphe and the Unknown Soldier's Tomb, thence to Les Invalides (Napoleon's Tomb). Return via the Place de la Concorde.

Late afternoon cruise on the Seine by "bateaux mouches," passing the Ile de la Cité and other points of interest. Dinner at the Eiffel Tower Restaurant.

Afternoon tour of the city, passing the Bourse and Central Markets, visiting the Palais de Justice; thence to the Left Bank, past the Luxembourg Gardens and Palace, to the Cathedral of Notre Dame, returning via the Place de la Bastille.

Afternoon drive to the splendid Royal Palace of Louis XIV and the Beautiful gardens at Versailles.

- SAT. AUGUST 1** Fly to Montreal.
The cost of the land tour — \$919 U.S. funds.

Here are the services it includes:

TRANSPORTATION IN EUROPE: First class rail with double sleeping compartments for overnight travel. Private motor coaches will be provided when travelling by motor.

HOTEL ACCOMMODATION: Moderate first class hotels. Bed in double room without private bath. A supplement for single rooms would be \$96.

MEALS: Three meals daily (meat breakfast): Table d'hôte lunch and dinner, without tea or coffee. In Edinburgh, London and Paris, breakfast only will be included.

SIGHTSEEING: A complete program with experienced local guides as specified in the itinerary.

TIPS: To the extent of the included tour services.

ADMISSION FEES: On scheduled sightseeing trips.

TAXES: European government taxes on tour services as presently applicable, except local airport taxes.

TOUR ESCORT: Throughout European portion of the tour.

The group air fare is \$312.50 return (jet), including the flights to London and Amsterdam. For a little over \$1,200 you will spend 43 days visiting 12 cities (less than \$30 a day). A chance in a lifetime, I would say.

Some of us pride ourselves on our tolerance but forget that tolerance must be directed towards the ideas and principles of others, never towards other persons because it then automatically implies that they

are not our equals. In order to be tolerant towards the ideas and principles of others we must have informed, convincing and well-founded principles of our own. This is basic!

—L. GRACE NICHOLLS

Nursing Profiles

Lois Evelyn (Gordner) Graham-Cumming has been appointed executive secretary-treasurer of the Canadian Nurses' Foundation. American-born, Mrs. Graham-Cumming received her bachelor of arts from



(Paul Horsdal, Ltd., Ottawa)

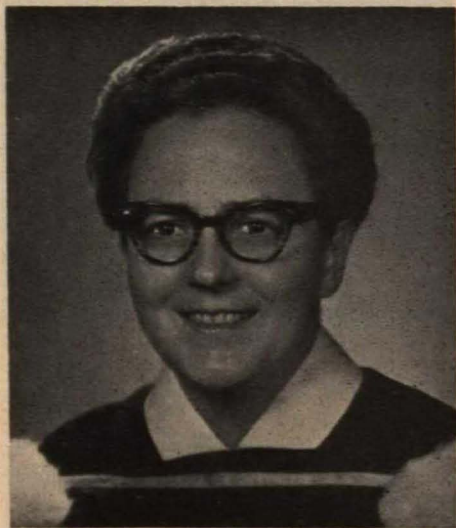
LOIS GRAHAM CUMMING

Earlham College, Richmond, Indiana and her Master of Nursing from Western Reserve University, Cleveland, Ohio. Her nursing career included posts at University Hospital, Cleveland; Frances Payne Bolton School of Nursing, Cleveland; Wesley Memorial Hospital, Chicago and the Veterans' Administration, Washington, D.C. She served as nurse director, United States Public Health Service, 1947-62. As part of her experience with USPHS, Mrs. Graham-Cumming assisted with the evaluation conference of the traineeship program and with the research and fellowship program.

In her present position she will be responsible for the administration of the Foundation's program. Since its incorporation, financial assistance has been granted to 19 nurses, permitting them to proceed with post-graduate study.

Saskatchewan's Centralized Teaching Pro-

gram for Nursing Students has a new director, **Phyllis H. Baker**. A graduate of The Atkinson School of Nursing, Toronto



PHYLLIS BAKER

Western Hospital, in 1957, Miss Baker joined the operating room staff of her hospital as a general duty nurse, remaining there until her enrolment in 1959 in the advanced course of study in operating room technique and management at the Montreal General Hospital. Completion of this period of study was succeeded by a year as a clinical instructor of student nurses in the M.G.H. operating room. In 1961, Miss Baker undertook further postgraduate preparation at McGill University School for Graduates Nurses and was granted her B.N. in 1962, having specialized in administration. She returned to M.G.H. as the clinical instructor for postgraduate students of operating room work, leaving earlier this year to assume her present duties with the Centralized Teaching Program.

Kathleen A. Dier, a 1945 graduate of Holy Cross Hospital, Calgary, has been appointed assistant professor of nursing, University of Saskatchewan, Saskatoon. She obtained her B.Sc. in nursing from the University of Alberta in 1960 and in May, 1963 completed requirements for the degree



KATHLEEN DIER

of Master of Science (Applied) from McGill University.

Miss Dier received her earliest nursing experience in such widely separated institutions as Shaughnessy Hospital, Vancouver, Leahi Hospital, Honolulu and Yellowknife Red Cross Hospital, N.W.T. Later, she joined Indian and Northern Health Services (now part of the Medical Services Directorate) and served as assistant matron in hospitals in Edmonton and Whitehorse. During this time she opened a nursing station at Cambridge Bay, N.W.T., on behalf of the public health services to whom she was loaned for a short time.



(Tisdall, Clark & Lesly, Ltd., Toronto)

CAROLYN ATTRIDGE

The Registered Nurses' Association of Ontario has awarded its first fellowship for graduate study to **Carolyn Attridge** who is presently enrolled at the University of Washington, Seattle, in a Master's program.

Her particular specialty will be nursing education as related to maternal and child health.

Miss Attridge is a graduate of the School of Nursing, McMaster University, Hamilton, from which she secured her bachelor of science in nursing in 1959. Following graduation she spent some time on the VON staff, Hamilton Branch, before joining the staff of Hamilton Civic Hospital as instructor in pediatric nursing.

The RNAO Fellowship, proposed by Miss Florence Emory in 1962, was established as a result of the concern of members over the limited number of nurses available to fill positions requiring advanced university preparation.



RUTH GAW

Sponsored by The Hamilton Health Association in conjunction with the Chedoke General and Children's Hospital, a new school of nursing is to be opened in September 1964 — the Hamilton and District School of Nursing. **Ruth M. Gaw**, a graduate of the Hospital for Sick Children, Toronto, has been appointed director of nursing. She secured her diploma in nursing education from McGill University following wartime service with the RCAMC, 1942-45, and joined the staff of the Queen Elizabeth Hospital of Montreal as nursing instructor and assistant director of nursing. In 1950, Miss Gaw was appointed director of nursing, Guelph General Hospital, returning to McGill University in 1960 to complete requirements for her degree. In 1961, she became director of nursing, Prince Edward Island

Hospital, Charlottetown, relinquishing this post in 1962 to join the Ontario Department of Health as an inspector of schools of nursing.

Temporarily, the new school will be housed in the Holbrook Pavilion, formerly part of the Mountain Sanatorium, Hamilton. It is anticipated that by 1965 a modern building will have been erected on the grounds of The Hamilton Health Association.



FRANCES WHITTLE

Frances Lillian Whittle, a graduate of Sherbrooke Hospital, Sherbrooke, Que. was recently appointed assistant director of nursing of her home hospital. Since her graduation in 1943, Miss Whittle has served her hospital loyally and efficiently first as a general duty nurse, later moving on to positions of increasing responsibility. For the past 14 years her duties as a head nurse have been her chief concern.

In 1953 she went to the Children's Hospital, Boston, for specialized preparation in the care of patients with poliomyelitis. This year she attended a refresher course in psychiatric nursing sponsored by the University of New Brunswick and completed the course of study in nursing unit administration offered jointly by the CNA and CHA.

Miss Whittle enjoys a wide variety of off-duty interests including sports, painting and gardening. Congratulations and good wishes are extended to her as she undertakes her new duties.



(The Telegram, Toronto)

LOUISE HALL

Alice Louise Hall was appointed assistant director of nursing in nursing research, Hospital for Sick Children, Toronto, during this past summer. A graduate of Royal Victoria Hospital, Montreal, she received her bachelor of nursing from McGill University in 1961 and returned to the staff of the Montreal Neurological Institute as assistant director of nursing where she remained until acceptance of her present post. Miss Hall has had a wide variety of nursing experience apart from administration. Following graduation she did general duty for a year in the Royal Edward Laurentian Hospital, Ste Agathe, Que. — a tuberculosis unit — and then joined the Montreal Neurological Institute nursing staff, remaining there until November 1950. The succeeding years were spent in hospitals in Texas, Trail, B.C., and Edmonton. In August 1956 Miss Hall returned to the MNI and the position of educational director.

An active participant in the affairs of her professional association, she was a member of the Nursing Advisory Committee for the Montreal division of the Red Cross Society, 1960-63; a member of the Core Committee of the Nursing Service Committee, ANPQ, 1962-63.

Her present position will provide an opportunity for her to explore a different side of nursing, fresh scope for an inquiring mind.

Giants of Nursing

On October 5, 1963 in Chatham, New Jersey, U.S.A., ISABEL MAITLAND STEWART, Professor Emeritus, former director of the Division (now Department) of Nursing Education, Teachers College, Columbia University, passed away. Her professional career formed a chapter, rich in achievement, in the history of nursing. Although



ISABEL MAITLAND STEWART

the larger portion of her life was spent in the United States, Canadian nurses have never forgotten that she was one of them and have taken just pride in her accomplishments. Born in Ontario, daughter of a Scottish Presbyterian missionary, Miss Stewart moved with her family to Manitoba when still a school girl. In 1895, age 17 years, she obtained a teaching diploma from the Manitoba Normal School and taught in the province's public schools for four years. In 1900 she entered the Training School for Nurses, Winnipeg General Hospital — a step from which nursing was to benefit for many years to come.

In 1908, with her arrival at Teachers College, Columbia University, her historic association with a fellow Canadian, Mary Adelaide Nutting, and with the development of nursing education in this institution, began. In 1909 Teachers College awarded Miss Stewart a diploma in hospital economics and she was appointed part-time assistant to Professor Nutting. By 1910, she had qualified for a Bachelor of Science degree and in 1913, she completed requirements for a Master of Arts. The remainder of her professional life was centred about Teachers College and nursing education — as instructor, assistant professor, associate professor and finally, following Miss Nutting's retirement in 1925, as director of the Division of Nursing Education and professor.

Miss Stewart's concern was chiefly the preparation of nursing teachers and the development of curricula for schools of nursing. Nurses from within and without her adopted country absorbed her teaching and returned to put her principles into practice, improving the performance level of their profession generally. Gradually, her influence spread farther afield: through her work with various professional associations, notably the National League of Nursing Education (now the National League for Nursing); through her services to governmental agencies as nurse consultant; through her achievements as an author — her most recent text which she co-authored, *A History of Nursing*, was published in 1962 when Miss Stewart was 84 years old.

The years brought many tributes. Columbia University conferred the honorary degree of Doctor of Humanities on her in 1954; University of Manitoba bestowed a Doctor of Laws, *honoris causa*, in 1956; Western Reserve University, Cleveland, had presented an honorary LL.D. as early as 1948; the National League of Nursing Education granted her the Adelaide Nutting award in 1947; Finland gave her its Medal

for Humanitarian Work in 1949. Many other honors could be mentioned.

In 1960, the Canadian Nurses' Association proudly welcomed her to its Biennial Convention in Halifax as the recipient of an honorary membership and as a very special guest speaker. Those who listened to her on that day must have shared the thrill of history brought to life — her reminiscences were of Adelaide Nutting and their years together.

Isabel Maitland Stewart was one of the truly great in nursing; her professional ideals were not restricted by boundary lines; her efforts were on behalf of nursing and nurses everywhere. In 1961 a Research Professorship in Nursing and Nursing Education was organized in her name at Teachers College in grateful recognition of her contribution. Her memory and her influence will live on.

ETHEL MILDRED CRYDERMAN, district director of the Toronto Branch VON, 1934-1959, president of the Canadian Nurses' Association 1948-50, died in Toronto on October 17, 1963. Ontario-born, a descendant of United Empire Loyalist ancestors, she obtained her early education in Walkerton, Ontario and graduated from the Toronto General Hospital in 1916. A few months spent in private nursing were followed by enlistment as a nursing sister with the Canadian Army Medical Corps and service until 1919. In 1918 her military contribution was recognized by mention in despatches.

After her discharge, Miss Cryderman prepared herself for that special field in nursing to which her career was later devoted. She received her certificate in public health nursing from the University of Toronto and joined the Toronto Department of Health as a staff nurse, 1921-24. Further study in England at Radcliffe Infirmary, Oxford and the Mothercraft Training Society, London, prepared her in midwifery and mothercraft. She returned to Canada and the Toronto Department of Health as a district supervisor, 1925-29. In 1929 her association with the VON began with her appointment as central supervisor, Victorian Order of Nurses for Canada.



ETHEL CRYDERMAN

Miss Cryderman had a tremendous capacity for hard work. In addition to the day-by-day activities of a demanding position, she participated in the work of various committees, professional and community; local, provincial, national and international. Canadian nursing benefited in general and the health services of her community were improved proportionately.

Among other offices, she served on the board of directors of the Community Chest; as vice-chairman of the Health Division, Toronto Welfare Council; chairman of the Public Health Section, RNAO; member of the board of directors, Canadian Arthritis and Rheumatism Society; president of the RNAO. In 1949 she headed the Canadian delegation to the ICN Congress in Stockholm and ably represented Canadian nurses at various meetings of the ICN Board of Directors.

Capable, knowledgeable, thoughtful, her leadership in her chosen field and in association work was outstanding. In 1960, the Canadian Nurses' Association conferred honorary membership upon her in grateful recognition of a life of service. In failing health for some time, she retired from Nursing in 1958 but her interest in her profession never wavered. Canadian nursing was enriched because she was part of it, and is the poorer for her loss.

Discontent is the first step in the progress of a man or a nation. — OSCAR WILDE

Role of the Family in Personality Development

JOAN M. WOOLISON

A sociological study of the main factors influencing social and emotional development from birth to adulthood.

In *Childhood and Society*, Erik Erikson identifies eight stages during the maturation process in which certain developmental tasks are learned by the individual.*

In infancy, the child develops a *sense of trust* through the love and attention he receives from those he is dependent upon — particularly from his mother who is sensitive in her response to his needs. In the second stage, the child develops *self-reliance or autonomy*. During this period he asserts himself in an attempt to find out what is tolerated and what is forbidden. In the next stage, the child's *sense of initiative* develops; he observes and imitates, using a vivid imagination. At this time he needs a great deal of freedom. In the fourth stage, he becomes *interested in completing a useful task*. At this point the child is in the first few years of school; thus many of these tasks must win acceptance for him among his playmates. In the fifth stage the child develops, or attempts to develop a *sense of identity*. Who am I? What do I want to be? What do people think of me? Can I make the right decisions? A struggle ensues as the child tries to reach a continuity with his past development; it is made more difficult by the rapid growth of adolescence and the social pressures of which he is becoming aware. Only the person who is secure in his identity can pass on to the sixth stage where he develops a *sense of intimacy*. He is now interested in satisfying the other person as well as himself and is capable of intimate warm friendships. The

seventh sense concerns parenthood. The individual develops an interest in producing and caring for children. The final stage is that of a *sense of integrity*. If the individual develops this, then he has accepted himself and his role in life.

Factors Influencing Development

The family is the child's major socializing agent. Because it is a primary group where warm personal relationships exist, the actions and attitudes of each family member exert a strong influence. Since it is a relatively permanent group, its teachings are reinforced throughout the child's years of growth.

What activities within the family group act to influence the development of the child into a well-adjusted member of society?

As mentioned in Erikson's theory of personality development, the child must accomplish certain tasks in order to be an integrated person. It is the family that provides the child with these tasks and helps him to accomplish them. By learning how to perform them, he is learning those things that constitute healthy personal growth in our society. He must learn to chew and swallow; to control his elimination habits; to walk, run and talk; to act in an acceptable manner. It is important that parents realize that each child develops at his own rate and accomplishes each task with a varying

Miss Woolison is a student at the Royal Jubilee Hospital, Victoria, B.C.

* Erik Erikson, *Childhood and Society*. New York, Norton, 1950.

amount of guidance; they must realize the importance of his readiness in understanding a new learning activity. Pushing the child to perform a new task when he is not ready for it only leads to anxiety and frustration. Success with a task results in happiness and sets the stage with future tasks; failure only leads to unhappiness, difficulty in facing future tasks and disapproval of society.

The Parent Role

Both parents are important influences in the child's development — mother more so than father in the first few years of the child's life since she is in closer contact with him. It is she who helps him pass through the first three stages of personality development while he is at the preschool age. The type of treatment he receives in his first years of life, at the time when he is most dependent, determines to a great extent what his later attitudes and beliefs will be.

In our society, the mother's role usually entails household management; bearing and rearing the children; meeting the affectional needs of her children and husband. By meeting her child's needs from the moment of birth she helps to instill a basic trust.

Feeding constitutes the child's earliest experience in social participation. His mother is his first and most important social contact. If she feeds her child in a relaxed and comfortable way, the child associates her with pleasure and learns to love her; on the other hand, rejection or indifference may lead to tense and negative behavior at a very early age. If the mother-child relationship is good, then the infant's positive response to his mother will generalize to others — the beginnings of socialization.

Father acts as a figurehead. His son identifies with him, seeks advice from him, works and plays with him, and admires and respects him. From this the child derives a strong sense of security. The daughter's dream of her future husband is moulded by the image of her father as a husband. His status as a working man links his family with the community; his occupation determines the family's position on the so-

cial scale, and thus the type of behavior, social expectations and obligations of his wife and family. His earnings influence the family's security. Financial difficulties are quite often the cause of marital tension — a tension that is easily transmitted to the child.

Mother and father together, in their parent role, provide the "home base" for their developing child. They enforce and reinforce social values by providing standards of behavior. In this way they help to perpetuate society's ideals of desirable behavior. Their response to questions regarding religion, together with the strength of their own belief are important in establishing a faith for the child.

Family Unity

The child's relationship with his brothers and sisters is another factor influencing his personality development. Sibling jealousy and rivalry for parental affection may lead to marked feelings of insecurity. The child who feels unloved may resort to antisocial behavior in order to gain attention, even though that attention is in the form of punishment. Patterns of mutual sharing, loyalty and helpfulness on one hand, and jealousy, competitiveness and conflict on the other hand, may be generalized to include other social relationships. To avoid undesirable traits stemming from poor sibling relationships, or more important, to create desirable traits, equal attention from each parent is essential.

When the child lives in an atmosphere of conflict, with quarrelling, nagging parents, his security is threatened; he may develop strong feelings of insecurity and a completely negative view of marriage. Parental tensions may be displayed in the form of unusually severe discipline. The parents may be so concerned with their own problems that they may unconsciously ignore the child. He may be troubled by conflicting loyalties if his parents are separated and he stays with first one, then the other. If he remains with one, he will lack either maternal or paternal care and an identifying figure.

When the marriage is stable, the child is free from tension. He is better able to learn and develop normally,

and his parents are better able to rear him with the care and attention he needs. This is important in creating the sense of parenthood in the child. Being part of a happy family creates in him a desire to have a family of his own.

Attainment of Independence

Generally, in our society, the offspring leaves his family to marry or work away from home. Thus the last factor in establishing a socially acceptable and stable personality in the child is helping him to become independent. This, indeed, is the eventual goal that the whole process of child-rearing is striving to achieve. To be independent he must know how to accept responsibilities. He must be able to make the adjustment from warm interpersonal family relationships to secondary groups where relationships are more impersonal. If his sibling interactions have been satisfactory, he will have learned the value of sharing — a quality that will help him to make friends more easily. He will know what

behavior is socially acceptable and what is not.

Summary

The method by which the parents rear their child, together with the way the family unit functions, determine the ease with which the grown child overcomes the wish to remain secure and free of responsibility.

The behavior the individual exhibits in society and the eventual behavior of his children is mainly the result of family influence on him as he matured from birth to adulthood.

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About Books

Primer of Clinical Measurement of Blood Pressure by George E. Burch, M.D. and Nicholas P. De Pasquale, M.D. 141 pages. The C. V. Mosby Company, St. Louis, Mo. 1962.

Reviewed by Mary E. Davis, Instructor, Nightingale School of Nursing, Toronto, Ontario.

This book was written primarily for the medical profession, "in the hope that it would stimulate thought, help to overcome errors in measurement and interpretation, instil confidence, and develop respect for the problems involved in the clinical measurement of blood pressure."

Since this procedure is frequently practised in nursing to assist the physician to collect data for assessment and treatment purposes, the book is a possible valuable source of reference for nurses. It is written in a clear, concise fashion. The introductory chapter presents the historical development of the recording of blood pressures,

followed by brief summaries of the principles, techniques, and precautions involved. The main emphasis is on the technique of measurement and the importance of accuracy. The physiology of arterial blood pressure is described in sufficient detail to provide the knowledge basic to an understanding of the technique of measurement; the factors that can effect arterial blood pressure; the factors that produce errors in measurement. The chapter concerning the use of blood pressure measurement in the diagnosis of disease might assist the nurse to gain an appreciation of the significance of the procedure and the degree to which the physician relies on the information it provides.

Psychology by Marian East Madigan, Ph.D. The C. V. Mosby Company, St. Louis, Mo. Ed. 3, 1962.

Reviewed by Myrtle Kutschke, Instructor,



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The stated purposes of the first edition published in 1950 were to give the student: a brief introduction to the study of psychology; a foundation for the learning process; an understanding of the biological and social forces affecting behavior; an appreciation of the usefulness of psychology as a means of improving everyday living. In the third edition, theories of personality development and therapeutic techniques are introduced; more space is given to mental illness.

The text is written for the student who has had no previous experience in psychology and, in particular, for the nursing student.

The reference list at the end of each chapter is annotated quite fully. Each chapter has an annotated list of films and filmstrips indicating the sponsoring organization and the date of production.

The discussion concerning the nature of learning and study techniques is very helpful; statements are documented. It is disappointing that the section on study technique dwells solely on preparation for examination. "Duty on the floors" is considered

application of classroom teaching. In an attempt to meet the needs of her patient, the student may initiate areas of independent study. This possibility is not considered. Later in the book, a sentence is devoted to the thought that the value of material being studied should be considered as well as grades!

Physiology is extremely elementary. For instance, the adrenal steroids are described as "officers of defense" and later as "cortin." The genetic information is inconclusive; the number of chromosomes is considered to be 24 pairs. No mention is made of new evidence to suggest that there are 23 pairs.

Unfortunately, nursing education is referred to as *training* in most instances. On one occasion, the term *nurse's education* is used.

The discussion of adolescence is fairly satisfactory. It is surprising that the author did not choose to relate it to the individual student. There is no opportunity for the latter to evaluate some of her own feelings in the light of normal adolescent feelings. In fact, any residual adolescent behavior that she may display is considered abnormal.

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The chapter devoted to the aged includes both physical and psychological needs, and the nursing care necessary to help meet the needs. The extent of the discussion of physical needs is surprising and should not be overlooked when such information is required.

The author achieves her stated aims. She has been most successful in establishing a foundation for the learning process. It would have been delightful to see application made to patient teaching. In helping the student to develop an understanding of the biological and social forces affecting behavior, the socio-economic situation of the adult is given no consideration. However, the influence of this factor in child development is made clear as are the influences of other environmental and hereditary factors. The space devoted to mental

illness briefly describes the common illnesses and treatments.

This book covers a great deal of material. It could be the beginning of reading in many areas. The chapters that serve as an introduction to psychology are probably on a par with other introductory texts on psychology.

Handbook for Private Duty Nurses by Ruth Le Roux, Reg.N., Chris Le Roux, Reg.N. and Voss Le Roux, Reg.N. 133 pages. Toronto Registry for Registered Nurses, Toronto, Ont. 1962.

Reviewed by Donalda Jeffery, private duty nurse, 88 Carlton St., Apt. 215, Toronto 2.

This book sets forth in a concise and pleasing fashion considerable information for the nurse engaged in private nursing. The duties and responsibilities of the nurse are reviewed and there is a chapter on the legal aspects of this type of service. Since policies related to signing on to cases, meal service, and locker room facilities of the different hospitals in the city of Toronto are outlined, this handbook would be of special value to newcomers to the city. The location of each institution and the means of transportation to them as well as available parking at each is also described.

Moral Treatment in American Psychiatry by J. Sanbourne Bockoven, M.D. 116 pages. Springer Publishing Company, Inc., New York. 1963.

This text contains information concerning institutional care of psychiatric patients in America since the 1800's. The history of such care is separated into three phases: 1. Moral treatment; 2. custodial non-treatment; 3. custodial re-education. The author believes that the "therapeutic research" phase is forthcoming.

The reader is taken on a visit to a typical mental hospital as it exists today. The lack of "individual" care in a large, impersonal institution, isolated from the community, is noted. Attention is drawn to the fact that "moral treatment," as practised in the early 1800's centred on a more individualistic approach.

Factors influencing the downfall of moral treatment and the development of "custodial non-treatment" are described in detail.

This is an interesting, well-written book. It would be of value to anyone interested in mental illness.

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DIRECTOR OF NURSING: Applications are invited for the position of Director of Nursing in 32-bed, modern General Hospital, 250-mi. east of Port Arthur. Operating Room experience essential. Excellent accommodation, pension plan, group insurance, etc. Salary commensurate with qualifications and experience. Apply to: Administrator, General Hospital, Manitouwadge, Ontario. (Phone 826-3251). 7-74-1

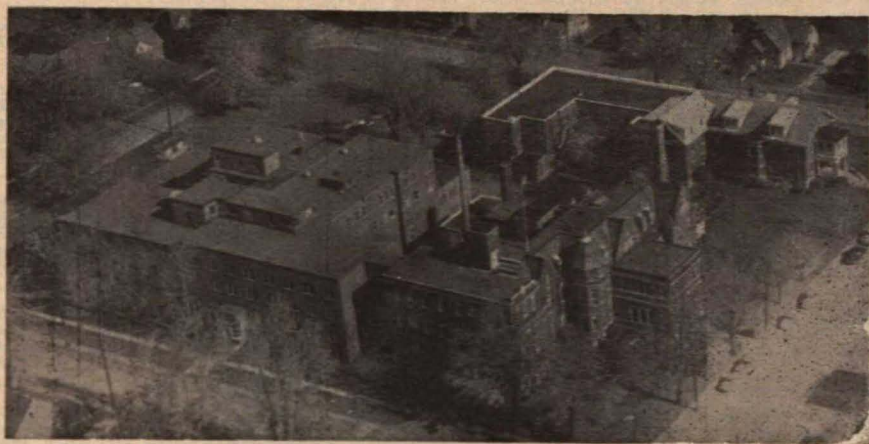
Director of Nursing Service for 33-bed General Hospital. Construction of a new hospital commences early in 1964. Salary commensurate with qualifications and experience. Apply stating qualifications to: Superintendent, Louise Marshall Hospital, Mount Forest, Ontario. 7-82-1

Supervisor — Hospital, and Registered Nurses for this 150-bed hospital. Salary scales as applicable in Ontario. All conventional benefits available. Apply giving details of training and experience to: The Director of Nursing, The Cottage Hospital, Pembroke, Ontario. 7-98-1

Registered Nurses for 100-bed General Hospital situated in Northern Ontario. Good personnel policies including O.H.A. pension plan. Salary scale as applicable in district. Residence accommodation if desired. For particulars, apply to: Director of Nurses, Lady Minto Hospital, Cochrane, Ontario. 7-30-1

Registered Nurses for 34-bed hospital, min. salary \$340, 3-wk. vacation with pay, sick leave after 6-mo. service. All staff — 5-day 40-hr. wk., 9 statutory holidays, pension plan & other benefits. Apply to: Superintendent, Englehart & District Hospital, Englehart, Ontario. 7-40-1

REGISTERED NURSES for small hospital. Good salaries and personnel policies. Accommodation available in modern nurses' residence. For further details apply: Superintendent, Niagara Hospital, Niagara-on-the-Lake, Ontario. 7-86-1



DIRECTOR OF NURSING

Required for this accredited 250-bed hospital in the Seaway Valley. University preparation required. Salary commensurate with qualifications and experience. Apply to Administrator, Cornwall General Hospital, Cornwall, Ontario.

SCIENCE and CLINICAL INSTRUCTORS

Required for School of Nursing expanding to 75 students. Salary commensurate with experience and qualifications. Good personnel policies, incl. four weeks paid vacation, nine statutory holidays, liberal policy for educational advancement.

Apply to:

**Director of Nursing Education
CORNWALL GENERAL HOSPITAL
CORNWALL, ONTARIO**

Registered Nurses. Applications and enquiries are invited for general duty positions on the staff of the Manitowadge General Hospital. Excellent salary and fringe benefits. Liberal policies regarding accommodation and vacation. Modern well-equipped 33-bed hospital in new mining town, about 250-mi. east of Port Arthur and north-west of White River, Ontario. Pop. 3,000. Nurses' residence comprises individual self-contained apts. Apply, stating qualifications, experience, age, marital status, phone number etc. to the Administrator, General Hospital, Manitowadge, Ontario. Phone 826-3251. 7-74-1A

REGISTERED NURSES for modern 52-bed General Hospital (Staff Nurses immediately) Situated in ski-resort village in Georgian Bay area. Starting salary \$300/m. Many employee benefits, 4-wk. vacation after 2 yrs. Opportunities for learning new skills, new experiences in hospital nursing, especially for graduates of large schools. Apply in writing or in person to the Superintendent, Centre Grey General Hospital, Markdale, Ontario. 7-76-1

Registered Nurses and Certified Nursing Assistants for well-equipped 75-bed hospital in progressive town of 5,500, situated midway between Winnipeg and the Canadian Lakehead. Reg.N., \$319 and Cert.N.Ass'ts, \$224/m with single room accommodation available in modern nurses' residence. Excellent personnel policies. For further information, please phone or write: The Director of Nursing, Dryden District General Hospital, Dryden, Ontario. 7-36-1

Registered Nurses, Certified Nursing Assistants (IMMEDIATELY) for 40-bed hospital in pleasant town of 5,000. 42-hr. wk. with good rotation shifts, providing long weekends every 4 wks. Good salaries and personnel policies. For further details and application, apply: Administrator, General Hospital, Espanola, Ontario. 7-41-1

Registered Nurses and Certified Nursing Assistants for 160-bed accredited hospital. Starting salary \$340 and \$235 respectively with regular annual increments for both. Excellent personnel policies. Residence accommodation available. Assistance with transportation can be arranged. Apply to: Director of Nursing, Kirkland & District Hospital, Kirkland Lake, Ontario. 7-67-1

Registered Nurses and Certified Nursing Assistants for immediate and future vacancies in this 42-bed hospital. Starting salaries \$335 and \$225, respectively. Accommodation in new residence available. Usual fringe benefits. For full information, apply to: Director of Nursing, New Liskeard and District Hospital, New Liskeard, Ontario. 7-83-1

Registered Nurses and Certified Nursing Assistants for 26-bed hospital. R.N. minimum salary \$340, maximum \$380, 28-day vacation after 1-yr. C.N.A. minimum salary \$244, maximum \$275, good personnel policies, 2-wk. vacation after 1-yr., 3-wk. after 2 yrs. Credit for past experience, \$5.00 increment every 6 mo., 40-hr. wk. 8 statutory holidays. Room & board \$45 per mo., 1-day sick leave per mo. Apply to: Mrs. G. Gordon, Superintendent, District Memorial Hospital, Box 37, Nipigon, Ontario. 7-87-1

Registered Nurses for General Duty in well-equipped 28-bed hospital, located in growing gold mining and tourist area, north of Kenora, Ontario. Modern residence with individual rooms; room, board and uniform laundry only \$45. 40-hr. wk., no split shift, cumulative sick time, 8 statutory holidays and 28 day paid vacation after one year. Salary range \$350 - \$375. Apply to: Matron, Margaret Cochenour Memorial Hospital, Cochenour, Ontario. 7-29-1

Registered Nurses for general duty in 14-bed modern newly built hospital. Salary: \$320-\$345 per mo. 40-hr. wk., 3-wk. vacation. Usual fringe benefits. Apply to: Miss F. Bourgeois, Hornepayne Community Hospital, Box 190, Hornepayne, Ontario. 7-134-1

Registered Nurses for General Duty in all departments including premature and new-born nursery, Isolation, Emergency, Recovery Room, and Intensive Care Unit. Good salary and personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario. 7-73-10

Registered Nurses for General Duty & Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 80,000 people. Salary: \$325 per mo. with annual merit increments, plus annual bonus plan, 40-hr. wk. Recognition for experience. Good personnel policies. Assistance with transportation can be arranged. Apply: Director of Nursing, Memorial Hospital, Sudbury, Ontario. 7-127-4

Registered or Graduate Nurses for modern 100-bed hospital located in summer resort district, 40-mi. from Ottawa. Apply: Director of Nursing, Public Hospital, Smiths Falls, Ontario. 7-120-2

General Duty Nurses for an accredited 66-bed hospital. Starting salary: \$325. Excellent personnel policies, pension plan, residence accommodation only 10 min. from downtown Buffalo. Apply: Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario. 7-45-1

General Duty Nurses for modern 100-bed hospital. Registered Nurses \$315-\$345 per mo., Graduates \$250-\$295; 40-hr. wk., benefits include accident, sickness and life insurance, hospital and medical insurance plans, & OHA Pension Plan. Apply: Miss Tillett, Director of Nursing, Leamington District Memorial Hospital, Leamington, Ontario. 7-69-1

General Duty Nurses for 100-bed modern hospital, southwestern Ontario, 32 mi. from London. Salary commensurate with experience & ability; \$315 basic salary. Residence accommodation available. Pension plan. Apply giving full particulars to: The Director of Nurses, District Memorial Hospital, Tillsonburg, Ontario. 7-131-1

General Duty Nurses & Certified Nursing Assistants for new 50-bed hospital with modern equipment. 40-hr. wk., 8 statutory holidays, excellent personnel policies & opportunity for advancement. Tourist town on Georgian Bay. Good bus connections to Toronto. Apply to: Director of Nurses, General Hospital, Meaford, Ontario. 7-79-1

Operating Room Nurses for general operating room work which includes cardiovascular, neurosurgery, genito-urinary, ear, eye, nose and throat and orthopedic surgery. Good salary and personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario. 7-73-10A

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**APPLICATION FOR GENERAL DUTY POSITIONS INVITED
FOR INFORMATION CONTACT:
THE DIRECTOR OF NURSING**

555 UNIVERSITY AVENUE, TORONTO, CANADA

OPERATING ROOM NURSE — Applications are invited for the position of Operating Room Nurse in 32-bed modern General Hospital, 250-mi. East of Port Arthur. P.G. course desirable but not essential. Excellent accommodation in self-contained apartment, pension plan, group insurance, etc. Salary commensurate with qualifications and experience. Apply to: Administrator, General Hospital, Manitowadge, Ontario. (Phone 826-3251). 7-74-18

Public Health Nurses (Qualified) for generalized program, by Stormont, Dundas and Glengarry Health Unit located in the Seaway Valley area. Minimum salary \$4,000. Annual increment. Allowance for experience. 5-day wk. Employer-shared (50-50) group insurance, portable OMERS pension plan, Ontario Hospital Insurance and P.S.I. coverage (medical, surgical and obstetrical plan). 3-wk. vacation, cumulative sick leave credits, one-half paid as bonus upon leaving after 3-yr. service. Generous car allowance. Reply in writing to: Dr. John A. Thomson, Medical Officer of Health, Box 1058, Cornwall, Ontario. 7-34-5

Public Health Nurse (Qualified) for generalized program. Salary range: \$4,000-\$5,000. Car provided, pension plan, attractive personnel policies. Cost of travelling to Kenora provided. Apply to: Dr. P. F. Playfair, M.O.H., Northwestern Health Unit, Box 250, Kenora, Ontario. 7-64-3

Public Health Nurses (Qualified). Salary range \$3,850 - \$4,600, required in a generalized program in rural and semi-urban area adjacent to Metropolitan Toronto. Excellent working conditions including pension plan, group insurance, and transportation arrangements. Write: Dr. R. M. King, York County Health Unit, 64 Bayview Avenue, Newmarket, Ontario. 7-84-2

Public Health Nurses (qualified) for generalized nursing service. Salary range: \$3,800-\$4,750 based on experience. Apply to: Dr. J. M. McGarry, M.O.H. St-Catharines-Lincoln Health Unit, St. Catharines, Ontario. 7-111-4

STAFF NURSES and O.R. and OBSTETRIC NURSES for 220-bed accredited hospital with School of Nursing. 1963 salary scale \$305-\$345. Postgraduate premium \$320-\$360. Usual personnel benefits, plus proximity to Ottawa, Montreal and Northern New York State. Apply: Acting Director of Nursing Service, Cornwall General Hospital, Cornwall, Ontario. 7-34-1

Staff Nurses for all nursing units of a 325-bed, fully accredited General Hospital located in downtown area. Orientation and in-service program. Rotating hours of duty. Attractive salary & fringe benefits. Apply to: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto 4, Ontario. 7-133-9

BERMUDA

Registered Nurses for General Staff. Salary commences at £52.10.0 per mo. Full maintenance in new residence. Transportation allowance. For full particulars, apply: Matron, King Edward VII Memorial Hospital, Bermuda.

QUEBEC

Assistant Head Nurses and Certified Nursing Assistants for 60-bed children's orthopedic hospital. Excellent personnel policies. Apply: Miss Flora M. Lamont, Reg.N., Administrator, Shriners Hospital for Crippled Children, 1529 Cedar Avenue, Montreal 25, Quebec. 9-47-42

Registered Nurses and Certified Nursing Assistants for 110-bed hospital for tuberculosis and other chest diseases. In the heart of the Laurentian Mountains, 55 miles north of Montreal. Apply: Director of Nursing, P.O. Box 1,000, Ste Agathe des Monts, Quebec. 9-57-1

SASKATCHEWAN

Registered Nurses (2) for 10-bed hospital. SRNA recommendations accepted. Please state qualifications. Accommodations and board \$34.50/m. Apply in writing to: R. Lyle Craven, Sec-Manager, Union Hospital, Beechy, Saskatchewan. Duties to commence as soon as arrangements are made. 10-5-1

Registered Nurses, Male or Female, for 500-bed modern General Hospital. General Duty positions available on general medical and surgical wards, pediatrics and maternity. Personnel policies comparable to Saskatchewan Registered Nurses' Association recommendations. Recognition given for experience. Must be eligible for Saskatchewan registration. For further information write: Director of Nursing Service, Regina Grey Nuns' Hospital, Regina, Saskatchewan. 10-109-7

General Duty Nurses, Saskatchewan registered, for 100-bed General Hospital. Salary based on experience, with recognition for P.G. courses and University training. Good personnel policies, residence accommodation and meals if desired. Apply to: Director of Nurses, Union Hospital, Weyburn, Saskatchewan. 10-135-2

GRADUATE NURSES for 8-bed hospital in southern Sask. Salary range \$315-\$392. Qualifications and experience considered. 3-wk. vacation plus statutory holidays, and 40-hr. wk., modern residence with T.V. Personnel policies on request. Apply to: Mrs. D. L. Knops, Sec. Treas., Union Hospital, Rockglen, Saskatchewan. 10-110-1

U.S.A.

Head Nurses \$436-\$505; Staff Nurses \$395-\$458 for California Hospital, 200 bed general duty in Sierra foothills. Single rooms and maintenance available for approx. \$30/m in modern nurses' residence complete with kitchen and swimming pool. Apply: Director of Nurses, Tulare-Kings Counties Hospital, Springville, California. 15-5-45

Registered Nurses for modern 374-bed General Hospital on the beautiful, warm Peninsula yet only 20-min. from the heart of cosmopolitan San Francisco. Openings in all nursing services including operating room, emergency room, and I.C.U. Excellent personnel policies, many extra benefits and opportunities for advancement. Telephone collect, Oxford 7-4061 or write: Director of Personnel, Peninsula Hospital, 1783 El Camino Real, Burlingame, California. 15-5-20

TO: Registered Nurses

FROM: The Director of Nursing

Ours is a progressive Psychiatric Ward in a Pediatric hospital setting, with 14 patients, ages 4 to 16 — blending a variety of Psychiatric conditions.

The nurse, in a warm homelike setting "lives" with the child through daily activities, participating with him in seasonal sports and community events.

Close association with the Social Worker, Occupational Therapist, Psychiatrists, Teachers and Nursing co-workers, provides learning opportunities and guidance for the creative nurse to develop skill in helping the child establish meaningful relationships.

ARE YOU INTERESTED?

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THE DIRECTOR OF NURSING

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Registered Nurses. Career satisfaction, interest and professional growth unlimited in modern, JCAH accredited 254-bed hospital. Located in one of California's finest areas, recreational, educational and cultural advantages are yours as well as wonderful year-round climate. If this combination is what you're looking for, contact us now! Staff Nurse entrance salary \$395 with automatic increases to \$455 per mo., supervisory positions at increased rate. Special area and liberal shift differentials paid. Excellent benefits including Blue Cross hospitalization and surgical coverage and liberal personnel policies. Professional staff appointments available in all clinical areas to those eligible for California licensure. Write today: Director of Nursing, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California. 15-5-12

Registered Nurses: Want to try the Land of Sunshine? Visit Hollywood and Disneyland? Swim all year 'round? Then work at Los Angeles (Calif.) County General Hospital where low-cost housing and meals let you save for a year long vacation! Starting salary is \$440; \$464 in 6 months. Shift bonus. Promotions rapid, good in-service program. Friends may have same days off. Write for full details, including information about California Registration. Citizenship not required. Director of Nursing, Room 2138, Los Angeles County General Hospital, 1200 No. State Street, Los Angeles 33, California. 15-5-3D

Registered Nurses excellent employment opportunities in one of the largest, most modern, and well-equipped voluntary (non-profit) hospitals in California. Its location, in beautiful Sacramento, offers unlimited entertainment and recreational facilities, and is the hub of all summer and winter sports activities. Starting salaries: General Duty \$410/m. days, \$435/m. P.M.'s and nights. Liberal fringe benefits including paid vacations, sick leave and holidays, free hospitalization insurance, employee discounts, Social Security, plus a retirement plan which includes free life insurance. Write: Personnel Department, Sutter Community Hospitals, 2820 "L" Street, Sacramento 16, California. 15-5-43

Registered Nurses for private 258-bed hospital for men, women and children. Staff Nurse salaries from \$380-\$450, differentials for evenings, nights, communicable disease, operating room and delivery. Opportunities in all clinical areas. Holidays, vacations, sick leave and health insurance. California registration required. Applications and details furnished on request. Contact: Personnel Director, Children's Hospital, 3700 California Street, San Francisco 18, California. 15-5-4

Registered Nurses for 233-bed modern hospital. Positions available — all services, no shift rotation. Liberal benefits, advancement opportunities, educational opportunities in area, equal opportunity employer. Apply: Director of Nursing Service, Kaiser Foundation Hospitals, San Francisco 15, California. 15-5-7

Registered Nurses for 350-bed hospital, openings in Southern California, Ventura, located between Santa Barbara and Los Angeles, city of 34,000; ideal year around climate and varied recreational facilities. Salary \$384 - \$466/m. Nurses' quarters \$20/m. Write: Personnel Department, Court House, Ventura, California 15-5-53

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Starting salary \$375 per mo. plus \$22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California. 15-5-39

Registered Nurses, Staff Nurses for permanent positions, various departments, days, eves., nights. Excellent starting salary, increments, benefits and working conditions in one of the largest and finest general hospitals in the West. For details write: Personnel Department, Queen of Angels Hospital, 2301 Bellevue Avenue, Los Angeles 26, California. 15-5-3G

General Duty Staff Nurses for 450-bed, fully approved hospital. Salary range per mo: Day Duty, \$438-\$458. P.M. and night duty, \$448-\$468. 40-hr. wk. Paid vacation. 7 paid holidays per yr. Accumulative sick time based on length of service. Liberal hospitalization plan. Nurses' residence. Rooms at reasonable rates. Registration or permit to work in California required. Address applications to: Chief Nurse, Southern Pacific Railroad Hospital, San Francisco, California. 15-5-68

GENERAL DUTY STAFF NURSES — Central California large General Hospital. Start \$413/m. Excellent in-service education programs; liberal personnel policies, shift differential. Apply: Personnel Director, San Joaquin County, Room 530, Courthouse, Stockton, California. 15-5-36

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon and night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California. 15-5-3C

Staff Nurses for 100-bed County Hospital located in the progressive San Joaquin Valley. Salary: \$395-\$458/m. Starting salary depends on experience. \$10 shift differential for evenings and nights. Occasional promotions to Head and Supervising positions. Liberal fringe benefits. Modern nurses' residence at nominal cost. Call or write: Director of Nurses, Tulare County General Hospital, Tulare, California. 15-5-44A

Nurses for new 75-bed General Hospital. Resort area. Ideal climate. On beautiful Pacific ocean. Apply to: Director of Nurses, South Coast Community Hospital, South Laguna, California. 15-5-50

General Duty Nurses for various departments including surgery for 72-bed hospital. Starting salary \$375 per mo. with periodic increases and fringe benefits. College town, tourist area, ideal climate. Contact: Superintendent, Alamosa Community Hospital, Alamosa, Colorado. 15-6-1

Executive Director generalized public health nursing agency. Potential for program expansion in rapidly growing community 45 minutes from NYC. Staff 8 full time, 5 relief nurses. Master's degree, administrative ability; experience required, salary open. Send résumé to Mr. Charles H. Ulrich, Chairman, Personnel Committee, Visiting Nurse Association, 60 Guernsey Street, Stamford, Connecticut. 15-7-4

General Duty Nurses for 54-bed hospital, minimum starting salary \$350 per mo., located near Miami and West Palm Beach. Apply: Director of Nurses, Belle Glade Memorial Hospital, Belle Glade, Florida. 15-10-3

REGISTERED NURSES: for 75-bed, air-conditioned hospital, growing community. Starting salary \$330-\$365/m, fringe benefits, vacation, sick leave, holidays, life insurance, hospitalization, 1 meal furnished. Write: Administrator, Hendry General Hospital, Clewiston, Florida. 15-10-1

HUMBER MEMORIAL HOSPITAL



HOSPITAL —

Newly expanded 350-bed hospital.
Progressive patient care concept.

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1963 schedule General Staff Nurses
\$325-\$375 per month and Certified
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HOUSING —

Furnished apartments available at
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High quality patient care and friendly
working environment, personal
recognition and professional development.

*You are invited to enquire concerning
employment opportunities to:*

**DIRECTOR OF NURSING, HUMBER MEMORIAL HOSPITAL,
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With the completion of new enlarged facilities and the addition of
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DIRECTOR OF NURSING EDUCATION

School of 75 students. B.Sc.N. in Nursing Education and experience required

SUPERVISORS

7-3:30 Surgical 50-bed unit; 7-3:30 Medical 50-bed unit; 3-11:30 General

Preference will be given to those with postgraduate education in Ward Administration

HEAD NURSE CLINICAL INSTRUCTOR

for Operating Room

CLINICAL INSTRUCTOR

for Surgical Unit. This position vacant June 1, 1964

OPERATING ROOM SUPERVISOR

This position vacant April 1, 1964

Stratford is a very interesting city with much to offer

Good personnel policies includes Hospitals of Ontario Pension Plan

Please apply to:

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**DIRECTOR OF NURSING, STRATFORD GENERAL HOSPITAL
STRATFORD, ONTARIO**

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Requires Registered Nurses for General Duty — Salary \$300 to \$345 M.S.I.

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DIRECTOR OF NURSING

BERWYN MUNICIPAL HOSPITAL - BERWYN, ALBERTA

ASSISTANT DIRECTOR OF NURSING SERVICE

Wanted for McKellar General Hospital. An active treatment hospital of 380 beds, with a progressive school of nursing. Postgraduate preparation essential; Baccalaureate Degree preferred.

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Director of Nursing,
McKELLAR GENERAL HOSPITAL,
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Staff Nurses (All Areas) Orientation and staff development programs, "nurse-saving" equipment, challenging working environment, individualized living accommodations in new air-conditioned cottages. Opportunity to participate in nursing practice of the finest quality in our 200-bed General Hospital, located along Lake Michigan shoreline, 30 mi. from Chicago. Starting salaries \$390-\$410 plus \$30 differential for 3-11 and 11-7. Write: Director of Nursing, Highland Park Hospital, Highland Park, Illinois, for detailed brochure. 15-14-3

Staff Nurses and Licensed Practical Nurses (Openings in several areas, all shifts). Minimum starting pay \$77 R.N.'s; L.P.N.'s \$61 per wk., experience considered, differentials paid for reliefs, nights. Every other weekend off in small community hospital 2 miles from Boston. Living quarters available. Contact: Miss Elizabeth B. Kennedy, R.N., Director of Nursing, Chelsea Memorial Hospital, Chelsea, Mass. 15-22-1

Staff Nurses 380-bed hosp. new 120 med-surg. unit. Trans. pd. 1st class air to Albuquerque and return within U.S. in exchange for 1-yr. emp. contract. Come to New Mexico "Land of Enchantment." Career opportunities, largest pvt. JCAH accredited hosp. in state; near U. of New Mexico, R.N. & B.S. pgm. Practical Nurse pgm. accredited state & NAPNE. Vacancies, Med-Surg. & occasionally O.B., Peds., & O.R., salaries \$315 per mo. even., night or O.R. with call; 6-mo. increases up to \$375; days \$300 per mo. with increases up to \$360. Rotation from day duty is required only when no person desiring permanent P.M. of night tour is available. Liberal personnel policies include: optional Blue Cross, Discount Hosp. Services, pd. sick leave cumulative to 5 wks., annual physical exam., vacation 1 yr. — 2 wks., 2 yrs. — 3 wks., 5 yrs. — 4 wks. Active in-service pgm. Occasional vacancy hosp. owned apts. New Mexico licensure as professional nurse & U.S. Citizenship (or Immigration Visa) required. Write or call collect: Mrs. Emily J. Tuttle, Dir. of Nursing, Presbyterian Hospital Center, 1012 Gold, S.E., Albuquerque, New Mexico. Phone 243-5611. 15-23-3

Registered Nurses for General Duty for 100-bed hospital. Starting salary \$300/m plus \$15 for 3-11 and \$20 for 11-7, automatic increase after 6 and 12 months. 40-hr. wk., employment benefits include 6 paid holidays, 12 days sick leave, two weeks vacation after 1st year, 1 week 1st year, Blue Cross and Blue Shield coverage paid in full, Social Security and Workmans Compensation coverage. College town. Apply: Director of Nursing Service, Jamestown Hospital, Jamestown, North Dakota. 15-35-1

Graduate Nurses for 450-bed non-sectarian acute General Hospital with NLN fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Opening of new main building has created attractive positions for Staff Nurses in medical, surgical, obstetric and pediatric divisions. Apartments available in immediate neighborhood. Apply: Miss Louise Harrison, Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th Street, Cleveland 6, Ohio. 15-36-1D

Staff Nurses for modern 400-bed tuberculosis hospital, suburban Cleveland, Ohio. Monthly salaries start at \$396 with semi-annual increments. Extra for night and relief duty, 5-day work wk., 3-wk. paid vacation, 6 paid holidays, liberal sick leave, comfortable accommodations in nurses' residence at low rate. Learn and earn at a progressive accredited hospital in a growing community. Write: Director of Nursing, Sunny Acres Hospital, Cleveland 22, Ohio. 15-36-1E

Registered Nurse (Scenic Oregon, vacation playground, skiing, swimming, boating & cultural events) for 295-bed teaching unit on campus of University of Oregon medical school. Salary starts at \$387. Pay differential for nights & evenings. Liberal policy for advancement, vacations, sick leave, holidays. Apply: Multnomah Hospital, Portland 1, Oregon. 15-38-1

Staff Nurses (All Clinical Services) Base salary \$350, opportunities for advancement, differential for 3-11 & 11-7 shifts, personnel policies, sick leave, retirement plan, 3-wk. vacation & laundry of uniforms. Orientation & in-service programs, housing available on campus. Apply: Director of Nursing Service, University of Texas Medical Branch Hospitals, Galveston, Texas. 15-44-5

ASSOCIATE DIRECTOR OF DEPT. OF NURSING (IMMEDIATELY). Salary range \$6,432-\$8,400, depending upon experience. Master's Degree required. Assists with the administration of all functions of the Department of Nursing in a large general teaching hospital center (approximately 1,300 beds) which includes: two general hospitals, a rehabilitation hospital, a sanatorium hospital, a sanatorium section and outpatient clinic. Directly responsible for the administration of nursing service in one of the general hospitals (approximately 500 beds) and the rehabilitation hospital (approximately 100 beds); Consults and plans with the director of the department of nursing in the administration of nursing service for the entire department of nursing in the hospital division and relieves the director when necessary. Liberal benefits. Apply: Post Office Box 67, Medical College of Virginia, 12th and Broad Streets, Richmond 19, Virginia. 15-47-2

HEAD NURSE for Orthopedic and Neurosurgery nursing unit, total of 30 beds. Nursing unit exceptionally well designed and equipped. New Teaching and Research University Hospital. Beautiful location on campus. Liberal fringe benefits including free tuition class (6 credits) after 6 months full time employment. Salary range \$443-\$539. Starting salary commensurate with experience and/or education. Applicant should have had 1 year experience in head nursing preferably on an orthopedic or neurosurgery unit. Apply: Director of Nursing Services, AA 310 University Hospital, 1959 Pacific Avenue, Seattle, Washington. 15-48-2E

Staff Nurses — University Hospital wants you if you want a challenging and rewarding position in a modern expanding 320-bed teaching and research hospital located on campus. Salary \$380-\$444/m. Opportunities in clinical research, premature center, chronic renal program, open heart surgery, and physical medicine, in addition to the general services. Liberal benefits including tuition free courses after six months. Contact: University Hospital, 1959 Pacific Avenue, Seattle, Washington. 15-48-2D

JEWISH GENERAL HOSPITAL MONTREAL QUE.

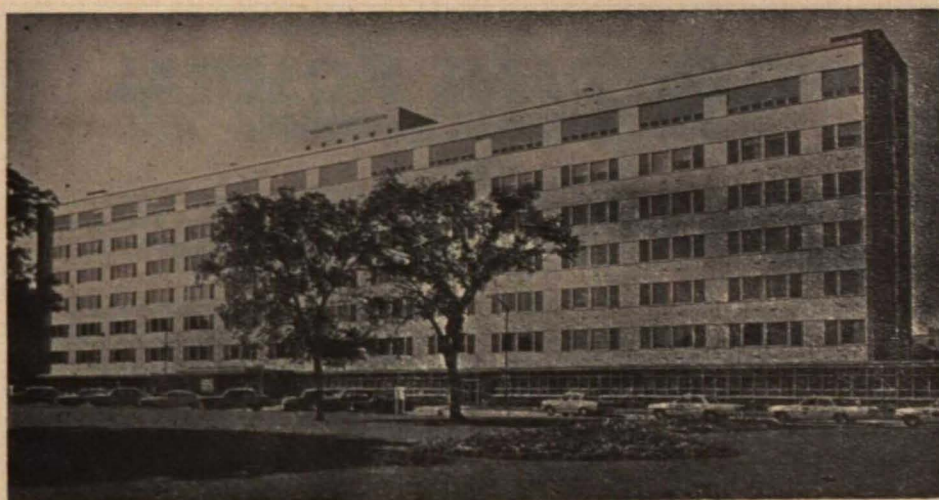


NURSING OPPORTUNITIES

In this modern 400-bed non sectarian hospital in Administration, Teaching, Staff Nursing. Certified Nursing Assistants also required. Openings in Psychiatry, Pediatrics, Obstetrics and Medicine and Surgery. Excellent personnel policies. Bursaries for post-basic courses in Teaching and Administration.

For further information, please write:

Director of Nursing, JEWISH GENERAL HOSPITAL, 3755 Cote St. Catherine Rd., Montreal, Que.



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is Recruiting General Duty Nurses for all Services

SEND APPLICATIONS DIRECTLY TO

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WINNIPEG 3, MANITOBA**

ASSOCIATE DIRECTOR OF NURSING SERVICE

General Hospital of 280 beds located in a progressive and friendly city in sunny southern Alberta. Population 27,000. School of Nursing with a maximum enrollment of 90 Students. Excellent personnel policies including coverage for hospitalization, medical services and a pension plan. Salary based on education and experience.

Write to:

**Director of Nursing,
MEDICINE HAT GENERAL HOSPITAL,
Medicine Hat, Alberta.**

GLENROSE PROVINCIAL GENERAL HOSPITAL

requires

SUPERVISOR and STAFF NURSES

For Handicapped Children's 30-40 bed Department. Opening date approximately
November 1st, 1963.

Also Graduate and Staff Nurses for Convalescent Units approx. 250-300 beds.

Apply in writing:

**THE DIRECTOR OF NURSING SERVICE,
Glenrose Provincial General Hospital, 10230-111th Avenue,
EDMONTON, ALBERTA.**

NOTRE DAME HOSPITAL

North Battleford, Saskatchewan

REQUIRES

General Staff Nurses and Certified Nursing Assistants for Medical, Surgical, Obstetrical and Pediatric Services. Forty hour week. Salary range: R.N. \$300 to \$375, C.N.A. \$205 to \$235 gross per month. Differential for evening and night duty for R.N.'s. Accommodation close to hospital if desired

Apply to:

**DIRECTOR OF NURSING SERVICE,
Notre Dame Hospital, North Battleford, Sask.**

ASSISTANT DIRECTOR OF NURSING

REQUIRED

For a 163-bed General Hospital.

Please reply to:

**Director of Nursing,
KIRKLAND AND DISTRICT HOSPITAL,
Kirkland Lake, Ontario.**

GENERAL DUTY NURSES FOR ALL DEPARTMENTS

Gross salary \$325 monthly with annual increments for 4 years to \$365.

Until registration in Ontario is established — \$300.

Rotating periods of duty — 40 hour week, 8 statutory holidays annually
— Annual vacation 21 days after one year.

Annual sick time 12 days after one year, unused portion cumulative to 36 days.

Hospitals of Ontario Pension Plan.

Ontario Hospital Insurance and Physicians' Services Incorporated, 50% payment by hospital.

Apply:

DIRECTOR OF NURSING, GENERAL HOSPITAL, OSHAWA, ONTARIO

THE SARNIA GENERAL HOSPITAL

Offers excellent opportunities for

REGISTERED NURSES AND REGISTERED NURSING ASSISTANTS

Sarnia is an industrial city located midway on the seaway, 60 miles north of Detroit and Windsor and 60 miles west of London. It is a resort area noted for swimming and boating as well as being located a reasonable distance from the skiing resorts in Northern Michigan.

The Hospital is modern, fully approved (JCAH), and has recently been expanded to 350 beds.

Positions are available in all services.

Salary scale with annual increments to the maximum. Additional salary allowance for two years or more acceptable experience or postgraduate certificate. Benefits include pension plan, 40-hour week, regular rotation of shifts with premium pay for evenings and nights.

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**PERSONNEL DIRECTOR,
SARNIA GENERAL HOSPITAL, SARNIA, ONTARIO.**

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Oshawa, Ontario

Requires for School of Nursing

CLINICAL INSTRUCTOR IN SURGICAL NURSING

with Certificate in Nursing Education

For further information, apply to:

**DIRECTOR OF NURSING,
Oshawa General Hospital, Oshawa, Ontario.**

GENERAL DUTY NURSES

SALARY RANGE \$327 - \$362

Required by Metropolitan Toronto for the new Riverdale Hospital, an 800-bed hospital for chronic and convalescent patients. Shift allowances for afternoon and night shifts. Cumulative sick pay and pension plans are in effect. Permanent positions, 40 hour week.

Apply:

**PERSONNEL OFFICE,
387 Bloor Street East, Toronto 5, Ontario.**

UNIVERSITY HOSPITAL

Saskatoon, Saskatchewan

APPLICATIONS ARE INVITED FOR:

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OPPORTUNITIES FOR EMPLOYMENT ARE AVAILABLE IN:

Medical, Surgical, Obstetrical, Pediatric, Psychiatric and Rehabilitation Services.

SALARY RANGE:

\$300-\$360 — Differential for evening and night duty — 40-hour week.

RESIDENCE:

Temporary accommodation if desired.

Apply to:

**DIRECTOR OF PERSONNEL, UNIVERSITY HOSPITAL,
Saskatoon, Saskatchewan.**

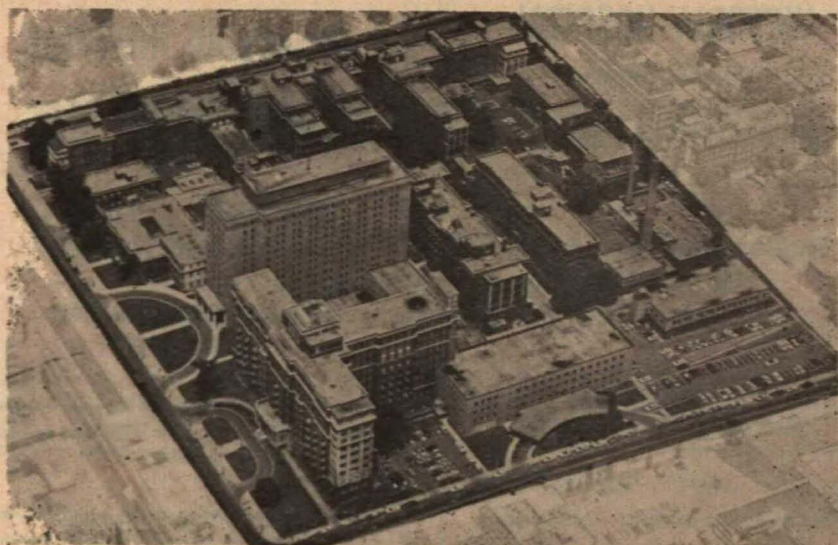
DIRECTOR, SCHOOL OF NURSING

For three year diploma school. Maximum enrollment of 90 students. School is a part of a busy General Hospital of 280 beds in a progressive friendly city located in sunny southern Alberta. Population approximately 27,000. Position created by a change in organization pattern establishing separate administrations for education and service. Excellent personnel policies including a pension plan. Salary based on education and experience.

Write to:

**The Administrator,
MEDICINE HAT GENERAL HOSPITAL,
Medicine Hat, Alberta.**

TORONTO GENERAL HOSPITAL



NURSING OPPORTUNITIES

for

REGISTERED NURSES AND CERTIFIED NURSING ASSISTANTS

Planned Orientation Programme — Inservice Educational Programmes
Opportunity to gain additional knowledge in specialized fields of nursing
Excellent personnel policies

Salaries commensurate with prevailing current salaries in Metropolitan Toronto

For information or application write to:

DIRECTOR OF NURSING, TORONTO GENERAL HOSPITAL
101 College Street, Toronto 2, Ontario

SOUTH WATERLOO MEMORIAL HOSPITAL

GALT, ONTARIO

REGISTERED NURSES — REGISTERED NURSING ASSISTANTS

\$320 - \$350 per month ————— \$196 - \$216 per month

257-bed fully accredited hospital. Positions available in all departments.
Hospital beautifully located on No. 8 Highway, 60 miles from Toronto by
401. Liberal Personnel policies.

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DIRECTOR OF NURSING

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LONDON, ONTARIO

Modern 1000-bed hospital

requires

**Registered Nurses for
all services**

and

**Registered
Nursing Assistants**

40 hour week - Pension plan
Good salaries and Personnel
Policies.

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ONTARIO

Offers excellent opportunities for

REGISTERED NURSES

and

**REGISTERED NURSING
ASSISTANTS**

In modern well-equipped 166-bed General
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in 1962.

Good salaries and modern separate res-
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nel policies and working conditions.

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REGISTERED NURSES

and

**CERTIFIED
NURSING ASSISTANTS**

for

360-bed accredited General Hos-
pital. Registered Nurses salary
range \$315-\$355 per month
with consideration for contem-
porary experience or special
preparation.

Certified Nursing Assistants
\$210 - \$240 per month.

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HOSPITAL
Windsor, Ontario.**

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A new 450-bed General Hospital, located
12 miles from the City of Toronto, has
openings for:

- (1) Supervisor for Nursing Office with
Nursing Service Administration Diplo-
ma.
- (2) Supervisor for Unit Administration on
Medical Ward.
- (3) Head Nurses and Assistant Head
Nurses for Medical and Surgical units.
- (4) General Staff Nurses in all depart-
ments.

Good personnel policies. Salary commen-
surate with experience and preparation.

*For information or application,
write to:*

**DIRECTOR OF NURSING
South Peel Hospital,
Cooksville, Ontario**

THE SCARBOROUGH GENERAL HOSPITAL

A new modern hospital located 10 miles from downtown Toronto
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REGISTERED NURSES REGISTERED NURSING ASSISTANTS

Opportunities are offered in Supervisory, Head Nurse and General Duty positions. Services are offered in Medicine, Surgery, Obstetrics, Pediatrics, Emergency and Intensive Care Units.

Salaries commensurate with prevailing current salaries for Nurses in Metropolitan Toronto and adjustable with experience and educational qualifications.

Progressive Personnel Policies, Pension Plan, Orientation and In-service Program.

For further information write to:

**DIRECTOR OF NURSING
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THE COLLINGWOOD GENERAL AND MARINE HOSPITAL

Invites applications for

Registered Nurse for Night Supervisor
Central Supply Room Supervisor
Pediatric Ward Head Nurse

Registered Nurses and Registered Nurse Assistants for General Duty in this modern 126-bed hospital. We have recently completed our new extension and require additional staff. Opportunities in all departments. The Town of Collingwood on beautiful Georgian Bay offers the finest in winter and summer sports.

For further particulars write:

**DIRECTOR OF NURSING SERVICES,
Collingwood General and Marine Hospital,
Collingwood, Ontario.**

SUPERINTENDENT OF NURSES

Required by 18-bed Private Hospital. Ontario registration required.

Registered Nurse with supervisory experience or experience as Superintendent of small hospital would fill requirements. Two room apartment with bath and all meals supplied for \$20 per month. Four weeks annual vacation per year, eight statutory holidays, hospitalization, medical-surgical and Group Insurance. Moving expenses up to \$50 refunded following six months employment. Salary scale will be forwarded following application.

Apply to:

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GRADUATE STAFF NURSES

Opportunities for men and women on all services including metabolism, rehabilitation, psychiatry, recovery room, medicine, surgery, pediatrics, obstetrics, operating room, and emergency room. Well planned orientation and in-service programs, tuition-free courses at Western Reserve University after 3 months employment, low cost housing in nurses' residence. Liberal personnel policies with premium for evening and night tours of duty. Starting rate based on experience and education. Staff nurse salary range \$385 to \$425. Write for more information and the booklet "New Horizons in Nursing," to:

DIRECTOR OF NURSING, UNIVERSITY HOSPITALS OF CLEVELAND
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MEDICAL SUPERVISOR POSITION OPEN AT UNIVERSITY HOSPITAL Saskatoon, Saskatchewan

POSITION OFFERS THE OPPORTUNITY TO:

1. Supervise in an active medical department.
2. Contribute to University and Diploma nursing student program.
3. Contribute to patient care as part of the medical team.

QUALIFICATIONS:

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2. Preparation and experience in supervision.

Apply to:

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GRADUATE STAFF NURSES

required for

MEDICAL AND SURGICAL AREAS

University teaching hospital. Applicants should be eligible for Ontario Registration. Personnel policies and further information may be obtained from:

DIRECTOR OF NURSING,
Kingston General Hospital, Kingston, Ontario.

SCHOOL OF NURSING

METROPOLITAN GENERAL HOSPITAL

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INSTRUCTOR IN PSYCHIATRIC NURSING

This is an opportunity to participate in the development of a progressive program which emphasizes educational nursing experiences for the student. The program consists of 2 basic, preparatory years followed by one year of Nursing Internship. One class of 32 students is admitted annually. **Duties include:** Instruction in Introductory Psychology and Mental Hygiene. Clinical and Classroom Instruction in Psychiatric Nursing. **Requirements:** University preparation in Nursing Education. — Salary differential for Degree. — Duties to commence August, 1964.

For further information, contact:

Director, School of Nursing, 2240 Kildare Road, Windsor, Ontario

NURSES

KENORA, ONTARIO

This resort town of 14,000 people has just opened a section of its new 100-bed hospital and in the not too distant future will be opening the second section for which nurses are needed. The hospital is wonderfully located on the shores of beautiful Lake of the Woods in Ontario, in the summer we have activities in swimming, boating, fishing and golfing and in the winter there is skating, curling, tobogganing, skiing and ice fishing.

A nurse's residence is available at a reasonable rate of \$20 per month for private room or \$15 per month for a double room. Cafeteria services are available at cost as well as a kitchen in the nurses' residence. Separate personnel policies for nurses are available and will be mailed on request. The starting salary is \$315 per month. Eight statutory holidays, sick leave, three weeks vacation with pay are some of the benefits of these policies.

All applications will be treated with courtesy and privacy.

Please apply to:

Administrator

Mr. A. C. DUNCAN,
KENORA GENERAL HOSPITAL,
KENORA, ONTARIO

WOODSTOCK GENERAL HOSPITAL

requires

1. ASSISTANT HEAD NURSE
for obstetrical department.
Postgraduate experience essential.

2. GENERAL STAFF NURSES

1. Obstetrics
2. Surgical Floor

Apply:

DIRECTOR OF NURSING,
Woodstock General Hospital,
Woodstock, Ontario.



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CRIPPLED CHILDREN

Requires

QUALIFIED EXPERIENCED PUBLIC HEALTH NURSES

YOU WILL RECEIVE —

- GOOD SALARY RANGE
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- PENSION PLAN
- FREE INSURANCE
- 3-MONTH TRAINING COURSE

You will deal directly with children,
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SUPERVISOR OF NURSING
ONTARIO SOCIETY
FOR CRIPPLED CHILDREN
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P.O. BOX 1700, STATION "R"
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in the General Operating Rooms (includes general surgery, cardiac, neurosurgery, plastic, ear, nose and throat and urology), Gynecological and Ophthalmological operating rooms. Salary commensurate with experience. Opportunities for promotion. Excellent fringe benefits including refund of tuition up to six points per semester.

For further information write:

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Baltimore 5, Maryland**

OPPORTUNITIES FOR RECENT GRADUATES

Staff positions will be available for Registered Nurses with special interest in rehabilitation and medical nursing. Those showing aptitude will have an excellent opportunity for early advancement to fill newly created posts which command the increases in remuneration as recommended by the Registered Nurses' Association of Ontario.

Starting monthly rate \$325-\$345. Private residence accommodation with adjoining bath available. Full maintenance \$40 monthly. Good location. Transportation advanced if requested.

Participation in clinical conferences, and in-service education program encouraged.

*For information contact
The Director of Nursing,*

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ST. JOSEPH'S HOSPITAL

Toronto, Ontario

REGISTERED NURSES and CERTIFIED NURSING ASSISTANTS

600-bed fully accredited hospital provides experience in Operating Room, Recovery Room, Intensive Care Unit, Pediatrics, Orthopedics, Obstetrics, General Surgery and Medicine.

Orientation and Active In-service program for all staff.

Salary is commensurate with preparation and experience.

Benefits include Pension Plan, Group Life Insurance, Sick Leave — 12 days after one year, Ontario Hospital Insurance — 50% payment by hospital.

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Apply

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SERVICE**

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30 The Queensway, Toronto 3, Ontario**

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With Postgraduate Course in Operating Room Technique and Management. Required for a 375-bed fully accredited General Hospital. Salary based on qualifications and experience. Fringe benefits include hospital and medical coverage, generous sick leave, three weeks' vacation and contributory pension plan.

For further information write:

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Windsor, Ontario.**

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for

110-bed "HOME FOR THE AGED" with 50-bed bed-care wing. Located on Grand River, Niagara Peninsula within 1 hour's travel to Hamilton, Niagara Falls and Buffalo, N.Y. Modern staff quarters optional.

For full particulars apply:

SUPERINTENDENT

stating qualifications, experience and remuneration

GRANDVIEW LODGE

Dunnville, Ontario

AFTERNOON SUPERVISOR

Required for fully accredited
General Hospital.

Apply stating qualifications and experience to:

Director of Nursing,
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HOSPITAL,
Leamington, Ontario.

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With postgraduate course in
OPERATING ROOM TECHNIQUE
AND MANAGEMENT

Required for
100-bed modern hospital.

Salary range \$340-\$380 per month

For further information write:

Director of Nursing,
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PORT COLBORNE GENERAL HOSPITAL

PORT COLBORNE, ONTARIO.

requires

REGISTERED NURSES

For recently expanded General Hospital, of 166 beds, within easy driving distance of American and Canadian metropolitan centres. Salary \$325 per month subject to adjustment review by Jan., 1964. Vacancies in the O.R. and medical and surgical wards.

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Requires

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Responsible for In-service program for Non-Professional Staff.

Apply:

DIRECTOR OF NURSING,
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REQUIRED FOR HEALTH BRANCH, B.C. CIVIL SERVICE

Positions available for qualified Public Health Nurses in various centres in British Columbia. SALARY: \$375 - \$462 per month; car provided. An opportunity for interesting and challenging professional service in this beautiful and fast-developing Province. For further information and application forms, apply to The Director, Public Health Nursing, Department of Health Services and Hospital Insurance, Parliament Buildings, Victoria, B.C., or to The Chairman, B.C. Civil Service Commission, 544 Michigan Street, Victoria, B.C. COMPETITION No. 63:101

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Required for School of Nursing with concurrent teaching program. Salary commensurate with experience and qualifications. Good personnel policies including four weeks paid vacation, nine statutory holidays, liberal policy for educational advancement.

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In small-sized General Hospital accredited. Located in attractive community 1 hour from Ottawa. Good personnel policies.

Apply:

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Kemptville, Ontario.

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requires

Two (2) qualified Instructors in Basic Nursing Arts and in Medical-Surgical Nursing.

Those interested in joining a progressive, dynamic school, are invited to write for more information to the:

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SALARY \$380 to \$425

(Commensurate w/experience)

\$3.00 per day differential for evenings. \$1.50 differential for nights. Positions available in Birthroom, Post Partum, Newborn Nursery and Medical - Surgical areas. Time and a half for overtime. Quarters available on hospital grounds. Other liberal fringe benefits.

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Registered Nurses for hospital work in northern Newfoundland and Labrador.

The Grenfell Mission offers challenging opportunities for satisfying investment of time and service.

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required for

110-bed active hospital in beautiful north-western British Columbia. Advanced preparation in nursing administration and postgraduate experience desirable. Salary commensurate with qualifications and experience.

Please address all enquiries to:

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GENERAL DUTY NURSES

required for

MEDICAL — SURGICAL — PEDIATRIC

Departments

In a 140-bed modern hospital. Excellent employee benefits program. Good personnel policies.

Address replies to:

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DIRECTOR OF NURSING

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The position involves responsibility for the organization of the Nursing Services and the School for Nursing Assistants. This modern hospital of 106 beds is planning an immediate expansion to 214 beds. University preparation and several years' experience in senior administration positions desirable.

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Are available at the Lakehead. The McKellar General Hospital and the City of Fort William, provide a friendly, pleasant atmosphere for work and play. Registered Nurses are invited to apply. Cost of transportation here will be prepaid for those staying one year. Basic salary: \$325 for nurses registered in Ontario. Good residence accommodation, \$30 per month.

For further information, write to:

DIRECTOR OF NURSING,
McKellar General Hospital,
Fort William, Ontario.

INSTRUCTORS

for

SCIENCE
SURGICAL-CLINICAL

University preparation required
Salary differential for degree

For further information apply to:

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Brandon, Manitoba.

OTTAWA CIVIC HOSPITAL

requires

GENERAL STAFF NURSES

for

OPERATING ROOM

MEDICAL

SURGICAL

OBSTETRICAL AND

PSYCHIATRIC

DEPARTMENTS

Apply

EDITH G. YOUNG, REG. N.,
Assistant Director and Administrator
of the
Department of Nursing

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for

(1) DIRECTOR OF NURSING

(2) SUPERVISOR (Nursing Service)

for

WESTERN MEMORIAL HOSPITAL
CORNER BROOK, NEWFOUNDLAND

Fully accredited General Hospital, 107 beds
with plans for expansion to 234 beds and
construction of new Nurses' Residence and
Training School.

Please apply, stating qualifications to:

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OF MONTREAL

Positions available for Registered Nurses, general duty in a recently enlarged and modernized 273-bed General Hospital in residential area. Progressive Patient Care currently in effect with intensive intermediate and self-care units established. Positions available also in Obstetrical Department. Salaries and policies are in accordance with the recommendations of the Association of Nurses of the Province of Quebec. Differential paid for permanent evening and night duty. For further information

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required

NURSE TECHNICIAN
TEAM

INTRAVENOUS MEDICATION
GOOD PERSONNEL POLICES

Apply:

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REGISTERED NURSES

required for:

82-bed hospital. Situated in the Niagara Peninsula. Transportation assistance.

For salary rates and personnel policies
apply to:

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Dunnville, Ontario

OPERATING ROOM SUPERVISOR

and

OPERATING ROOM
STAFF NURSES

Required for fully accredited
General Hospital.

Apply giving qualifications and experience to:

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MCGILL UNIVERSITY

Graduate Course in

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- 2) Operating Room Technique

CLASSES: Mar. 1 and Sept. 1

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(including operating room)

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3801 UNIVERSITY STREET
MONTREAL 2, QUE.**

UNIVERSITY OF BRITISH COLUMBIA

School of Nursing

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NURSING**

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GRADUATE NURSES**

Both of these courses lead to the
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A six month Clinical Course
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Operating Room Principles and Advanced Practice.

The course commences in September of each year. Maintenance is provided, and a reasonable stipend is given each month. Enrolment is limited to a maximum of ten students.

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THE DIRECTOR OF NURSING

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The largest eye hospital in the United States offers a six-month course in Nursing care of the Eye to Graduates of Accredited Nursing Schools. Operating Room Training is scheduled in the course.

- Full maintenance and a stipend of \$237 per month for the first three months, \$247 per month for the last three months, plus maintenance.

- Registration Fee is \$20

- Course starts September 16th & March 16th. Ophthalmic Nurses in great demand for hospital eye departments, operating rooms & ophthalmologist's offices.

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Director of Nurses,
WILLS EYE HOSPITAL,
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Philadelphia 30, Penna.

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1. (a) Six month clinical course in Obstetrical Nursing.

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Classes following the six month course in Obstetrical Nursing.

- (c) Eight week course in Care of the Premature Infant.

-
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-
3. Six month course in Theory and Practice in Psychiatric Nursing.

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Montreal, P.Q.

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Offers a 6 month Postgraduate Course
in Operating Room Management and
Technique.

Classes March and September.

— Reasonable monthly stipend —

*For information and details of the Course,
apply to:*

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SERVICE,
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30 The Queensway,
Toronto 3, Ontario.**

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KENTVILLE, N.S.

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Month Course in *Tuberculosis Nursing*,
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1. Full series of lectures by Medical and
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2. Demonstrations and Clinics.
3. Full maintenance, salary and all staff
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**DIRECTOR OF NURSING
NOVA SCOTIA SANATORIUM
KENTVILLE, N.S.**

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NEW BRUNSWICK
DEPARTMENT OF HEALTH
PROVINCIAL HOSPITALS OF
NEW BRUNSWICK**

Located at Campbellton and Lancaster.
(Both English speaking and bilingual Eng-
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REGISTERED NURSES: Salary \$3,336-\$4,056
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Annual increments of 5 per cent. Full Civil
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4 months special Eye, Ear,
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Approved Students enter under
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DIRECTOR OF NURSING

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OFFERS

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gust 31, 1964.

For complete information write to:

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INDEX FOR 1963

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